Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death **Physician** Month Year Dowd 1105 AM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 5. Social Security Number Hospital if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 3-2-7. Age (In yrs. last birthday) **Funeral** Days Hours 239-26-1197 Months 1 □ M 2 X F Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No **Funeral Director** MD Himore 10e. Street and Number 10g. Citizen of What Country? 21229 ationa more 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Health Care 15. Decedent's Education (Specify only highest grade completed) Secondary (0-12) College (1-4or 5+) 2th 17. Father's Name (First, Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be avis tora ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Morris Maniego 20c. Location -20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, mD ٥ 4 Donation 5 Other (Specify) 21. Sign tive of Funeral Service License 21229 Baltimore, MD 23a. Part1. Enter the disease, or complications the shock, or heartfailure. List only one caus caused the death. Do not enter the mode Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes ☐ Ho Month 5 ☐ Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 TYes 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 1 Inpatient ₽₽₽R/Outpatient 3 DOA 4 Dursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27 Manner of Death Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check on Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29b. Signature and title 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Bowden, Jeffie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day 200<sup>Year</sup> August 9 Frank S. Bell 6:55 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Villa Nursing Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Ye Oct 22, 1 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Mary Land 212-18-8488 Director 1921 Usual Residence of Decedent the Maryland a or 28a-f show be notified at 10h. County 10c. City, Town or Location 10d Inside City Limits Maryland Director Baltimore 1 ☐ Yes 2 No Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or any injury or other traumatic event, the Medical Examiner must be n 21228 221 Newburg Avenue USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 1 XYes 2 No 1942 If Yes, Give Year or Dates: 1945 Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐No Specify. 3 ☐Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank S. Bell Rosa Burkett ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary C. Bell, Daughter 405 Wrenleigh Drive Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park 08/13/07 Woodlawn, Maryland 21. Signature of Funeral Services in consection of Thomas Gregor Name and Address of Facility
MacNabb Funeral Home, P.A. 301 Frederick Road Cátonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EREBRO VASCULAR **Physician** THEROSCHEROTIC DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical as 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of geath? been si 1 Yes 2 No 3 Probably 4 Unknown Completed MELLITUS 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy certificate performe 2 No 1 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 ☐ Yes Other: 0 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

SXV

State Registrar

DHMH 17 Rev 1/2001

AUG 1 4 2007

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2835

wee .

SUITE 203,

|                            |  |                | For<br>1_ State  | State o  | f Marylan                          | -                                | ırtment<br><i>tificate</i>   |                   | ealth and I                            | Mental Hy                  | -                        | -0.01            | ( . 0 0 (                        |
|----------------------------|--|----------------|--|--|------------------------------------|----------------------------------|------------------------------|-------------------|--|----------------------------|--------------------------|------------------|----------------------------------|
|                            | - A  | d              | Registrar  1. Decedent's Name (First,  | , Middle, Last)  |                                    | Cel                              | uncale                       | OI L              | veaur                                  | 2. Date of D               | Reg. No.                 | UUI              | 3. Time of Death                 |
|                            | Physici  |                | Elea:  |  | a Brov                             | ผาา                              |                              |                   |  | Augus.                     | Day                      | 2D07             | 1:00 PM                          |
|                            | /Medic<br>Examin   |                | 4a. Facility Name (If not in   | stitution, give street and nu                          | mber)                              |                                  | 4b. City, To                 | own, or l         | Location of Death                      |                            | -                        | unty of Death    |                                  |
|                            |  |                | baltimore 1  | vashington   |                                    |                                  | GI                           | n                 | Burni                                  |                            | Ar                       | nne f            | trundel                          |
|                            | Funeral  |                | 5. Social Security Number  | 6. Sex ✓   | 7. Age (In yrs.                    | last birthday)<br>Yrs.           | If Under 1<br>Months         | Year<br>Days      | If Under 24 Hrs.<br>Hours Min.         | 8. Date of Bi<br>(Month, D | ay, Year)                | Coui             | place (State or Foreign<br>ntry) |
|                            | Director   |                | 215-38-5070<br>Usual Residence of Deced  | lent   | 73                                 |                                  |                              |                   |  | Jan 19                     | , 1934                   | Ma:              | ry1and                           |
|                            | yland<br>how<br>at   |                | 10a. State 10b. 0  | County   | 10c. Cit                           | y, Town or Lo                    | cation                       |                   |  |                            |                          |                  | 10d. Inside City Limits          |
| •                          | e Ma<br>3a-f s<br>tiffied  | Director       | Maryland An  | ne Arundel   |                                    | Sev                              | 7ern                         |                   |  |                            |                          |                  | 1 □Yes 2 No                      |
| 5                          | vith th  | Dire           | 10e. Street and Number   |  |                                    |                                  | 10f. Zip C                   |                   |  |                            |                          | of What Cou      |                                  |
| B 1200 r                   | death with the Maryland ms 23a or 28a-f show r must be notified at   | Funeral        | 1869 Richfi  |  | adent Ever in II                   | S 13 1                           |                              | 1144              |  | necify Vec or N            | -                        | ted Sta          |                                  |
| 3.                         | or Item  | Fun            | 11. Marital Status 1 ☐ Never Married 2[  | ☐ Married 1 ☐ Yes                                      | edent Ever in U<br>prces?<br>2 XNo |                                  |                              |                   | panic Origin? (S<br>n, Mexican, Puert  | o Rican, etc.)             | 0- 1-4.                  | Black, White,    |                                  |
| 6 1/3                      | ours a<br>ral", o<br>Exarr   | þ              | 3 ☐ Widowed 4 🛛 Di   | ivorced If Yes, Gi<br>Year or D                        | ve<br>ates:                        |                                  | I□Yes 2[                     | XNo.              | Specify:                               |                            | Sp                       | ecify: B.        | lack                             |
|                            | 72 ho<br>'natuı<br>dical   | Completed      | 15. De<br>(Specify only  | ecedent's Education v highest grade completed)         |                                    | 16a. Deced                       | lent's Usual<br>kind of work | Occupa<br>done di | tion<br>uring most of wor              | king                       | 16b. Kind                | of Business/In   | dustry                           |
| 7                          | within<br>lene.<br>than "  | Id m           | Elementary/Secondary (   | (0-12) College (                                       | 1-4or 5+)                          |                                  |                              |                   |  |                            | D.                       | 114 - C          | -11-                             |
| d 21                       | filed v<br>Hygie<br>other  |                | 12<br>17. Father's Name ( <i>First, I</i>  | <br>Middle, Last)                                      |                                    | Care                             | eria                         |                   | iger<br>18. Mother's Nan               | ne (First, Middle          |                          | blic So          | chools                           |
| Solan                      | lld be<br>lental<br>ked c  | To Be          | William  | H. Savoy   |                                    |                                  |                              |                   | Alice                                  |                            | Smith                    |                  |                                  |
| Maryland                   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. |                | 19a. Informant's Name/Re   |  |                                    | 19b. Mailir                      | g Address (S                 | Street a          | nd Number or Ru                        |                            |                          | own, State, Zip  | Code)                            |
| Ma Ma                      | and 2<br>ealth<br>n 27 I   |                | Zella Brown  |  |                                    |                                  |                              |                   | Drive                                  |                            |                          | land 2           |                                  |
| ELE<br>Baltimore,          | Pages 1<br>nent of H<br>nt; If Ite<br>iry or otl   |                |  | nation 3 Removal from                                  | State                              | Place of Dispo<br>cemetery, crer |                              |                   |  | Date                       |                          | ion - City or To |                                  |
| 重量                         | it. Pa<br>rtmen<br>rtant:<br>njury   |                | 4 ☐ Donation 5 ☐ O   |  | Nat                                |                                  | larmon                       |                   | em Park                                | 8/15/07                    | Land                     | over, l          | Maryland                         |
| Ba                         | permit. Departn Imports any Injt   | 4 8            |  | Q(1)   |                                    | pg                               | nalds                        | on I              | Tuneral<br>lis Roa                     | Home &                     | Cremat                   | ory, P           | .A.                              |
|                            |  |                | 23a. Part Enter the dise   | ase, or complications that of                          | aused the deat                     |                                  | 0.00                         |                   |  |                            |                          | aryran           | Approximate<br>Interval Between  |
|                            | hysician   | 8 9            | Immediate Cause (Final disease or condition  | re. List only one cause on e                           |                                    | ~~                               | M                            |                   |  |                            |                          | 1                | Onset and Death                  |
|                            | /Medical   |                | resulting in death)  | aDue to  | r as a conseq                      |                                  | . \                          |                   | - î                                    |                            | 4                        | Territoria       |                                  |
|                            | Examiner   | L              | Sequentially list conditions   | , cho  | MC 1                               | omt soc                          | que                          | P                 | nombra                                 | any                        | dise                     | me.              |                                  |
|                            | led sit  | Examiner       | if any, leading to immediat<br>cause. Enter Underlying<br>Cause (Disease or injury | te Due to  | (or as a conseq                    | juencé of):                      |                              | •                 |  | ι                          |                          |                  |                                  |
|                            | execuing and al-trar   | xan            | that initiated events<br>resulting in death) Last                                  | C  | (or as a conseq                    | juence of):                      |                              |                   |  |                            |                          |                  |                                  |
| 68760,                     | eath certificate be executed<br>attending physician and<br>for use as the burial-transit   | edical E       |  | d  |                                    |                                  |                              |                   |  |                            |                          |                  |                                  |
|                            | rtificat<br>ng phy<br>as th  | Nedi           | IF FEMALE:   |  |                                    |                                  |                              |                   |  |                            | 1                        |                  |                                  |
| Вох                        | ath ce<br>ttendii<br>or use  | Physician/M    | 23b. Was decedent pregn<br>in the past 12 months                                   | 1 ☐Live I  | tcome pf pregna<br>pirth 2  Feta   | aldeath 3□                       | Ectopic preg                 |                   |  |                            | 23d                      | . Date of delive | ery<br>Day Year                  |
|                            | the a  | /sici          | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4□Pregi<br>9□Unkn                                      | nant at time of o                  | death 5□                         | Other (spec                  | ify)              |  |                            |                          | WOITH            | Day                              |
| P.0                        | that tl<br>ed by<br>detac  | , Ph           |  | onditions contributing to d                            | eath but not res                   | ulting in the ur                 | nderlying cau                | se give           | n in Part I.                           | 23e. Did                   | tobacco use              | contribute to t  | he cause of death?               |
| Division or Vital Records, | The law requires that the death certifice has been signed by the attending the has been signed by the attending to the analysis.   | d by           |  |  |                                    |                                  |                              |                   |  | 1 🗆                        | Yes 2 1                  | No 3□ Prot       | pably 4 Unknown                  |
| မ္မ                        | av rec<br>s bee<br>2 shou  | Completed      |  |  |                                    |                                  |                              |                   |  | 24a. Wa                    |                          | 24b. Were auto   | opsy findings available          |
| a.                         | The lav<br>ate has I<br>page 2 s   | mo             |  |  |                                    |                                  |                              | -                 |  | auto<br>peri<br>1∏ Yes     | opsy<br>formed?<br>20 No | death?           | mpletion of cause of<br>2 ☐ No   |
| /ita                       | clan:<br>ertifica<br>ector,  | Be             | 25. Was case referred to rexaminer?  |  |                                    |                                  |                              |                   | 26. Place of Dea                       |                            |                          |                  |                                  |
| <u>ا</u>                   | Physic<br>this c   | 2              | 1 ☐ Yes 2 No   |  |                                    | ER/Outpatien                     |                              | Othe              | 4 ⊔ Nursing H                          | ome 5□Res                  |                          |                  | (y)                              |
| no<br>Lo                   | ding I<br>J.<br>After<br>funer   | ion:           |  | Pending 28a. Date (Moning investigation                | th, Day Year)                      | 28b. Time of<br>Injury           | M 280                        | Injury<br>Work'   | at<br>?<br>es 2 ☐ No                   | 28d. Describe              | how injury o             | ccurred          |                                  |
| /Isi                       | Attending Physician: r death. ector; After this certific by the funeral director,  | ficat          | 3 ☐ Suicide 6 ☐  | Could not be 28e. Place                                | of injury - At h                   | ome, farm, str                   |                              |                   | C5 2 [] NO                             | 28f. Location              | (Street and N            | lumber or Rura   | al Route Number,                 |
| Ö                          | s after<br>al Dire   | Certification: | 4 ☐ Homicide   | build  | ing, etc. (Specia                  | fy)                              |                              |                   |  | City or To                 | own, State)              |                  |                                  |
|                            | d hours  |                | (Check only 2 M  | ertifying Physician: To the ledical Examiner: On the b | e best of my kno                   | owledge, death                   | n occurred at                | the tim           | e, date and place<br>inion, death occu | and due to the             | e cause(s) an            | d manner as s    | stated.                          |
|                            | To the Hospital or Attending Physician within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.  | Medical        | one) 29b. Signature and title of   | and man  | ner stated.                        |                                  |                              |                   | number                                 |                            | <u> </u>                 | igned (Month,    |                                  |
|                            | F ≥ F 8  |                | Az   | Par  | A 4                                | \                                | 1                            | 10                | Rath                                   |                            | A                        | -5               | 0 2 007                          |
|                            | 1  |                | 30. Name and addr ss of  | person who completed caus                              | FULL<br>se of death (Ner           | n 23a) (Type.                    | Print)                       | 14.               | ,-1                                    |                            | TIMOV                    | 0) (             | U 2007                           |
|                            | $\mathcal{O}$  |                | anplen you   | Sump : . 301   | 1935                               | al DR                            | we,                          | Gl                | In Bur                                 | mes                        | no                       | . 2_             | 1061.                            |
|                            | Sta<br>Registr   |                | 31. Date filed (Month, Day   | G 1 4 2007 32.   | gistrar's Signa                    | ature A                          | parti                        |                   |  |                            |                          |                  |                                  |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                     |   |                           | 1 - For<br>State<br>Registrar   | State of Mary  | •                               | artment of F<br>rtificate of                                  |   |   | ene 0 0 7                                    | 26001  |
|---------------------|---|---------------------------|---|--|---------------------------------|---|---|---|--|--|
|                     | Physici   | an                        | 1. Decedent's Name (First, Middle, La   | ST)<br>TKER  |                                 |   | 1   | Date of Death<br>Month                      | Day Year                                     | 3. Time of Death                                 |
|                     | /Medic<br>Examin  | al                        | 4a. Fecility Name (If not institution, giv  |  |                                 | 4b. City, Town, o   | r Location of Death   | ugust 1                                     | 4c. County of Dea                            |  |
| 1                   |   | er                        | FRANKLIN WOOD   |  | 2123ME                          | Rossv   |   |   | Baltimo                                      |  |
|                     | Funeral<br>Director   |                           | 210-12-8038   | 6ex 7. Age (In<br><b>1</b> 7. Age (In  | yrs. last birthday<br>5 Yrs.    |   | If Under 24 Hrs. 8  | Date of Birth<br>(Month, Day, Y<br>07/06/19 | (ear) 9. Bir                                 | thplace (State or Foreign<br>buntry)<br>ryland   |
|                     | /land   |                           | Usual Residence of Decedent  10a. State 10b. County   | 10   | c. City, Town or L              | ocation   | · · · · · · · · · · · · · · · · · · ·                           |   |  | 10d. Inside City Limits                          |
|                     | e Man<br>la-f sh<br>ulled   | ctor                      | Maryland Baltimon   | re i   | Dundalk                         |   |   |   | -  | 1 ☐ Yes 2 QNo                                    |
|                     | er death with the Maryland<br>Itams 23a or 28e-f show<br>har must be notified at  | Funeral Director          | 10e. Street and Number<br>1833 Marshall Road  | i  |                                 | 10f. Zip Code<br>21222  |   |   | U.S.A.                                       | ountry?  |
| Maryland 21215-0036 | after<br>or ita   | by                        | 11. Marital Status  1 Never Married XX Married 3 Widowed 4 Divorced   | 12. Was Decedent Ever<br>Armed Forces?<br>↓□Yes 2 □ No<br>If Yes, Give<br>Year or Dates: | 1942-<br>1945                   | Was Decedent of H If Yes, specify Cuba  ¹ ☐ Yes XX No         | lispanic Origin? (Specit<br>an, Mexican, Puerto Ric<br>Specity: | y Yes or No-<br>can, etc.)                  | 14. Race - Ame<br>Black, White<br>Specify: W |  |
| 15-(                | 72<br>nat   | Completed                 | 15. Decedent's E<br>(Specify only highest gr  | ducation<br>ade completed)   | 16a. Dece<br>(Give              | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | ation<br>during most of working<br>d)                           | 16  | b. Kind of Business                          | /Industry  |
| 212                 | yene.   | ошо                       | Elementary/Secondary (0-12)   | College (1-4or 5+)   |                                 | Worker  | -,  |   | ethlehem S                                   | Steel  |
| pu                  | be filed within tal Hygiene. d other than '   | Be                        | 17. Father's Name (First, Middle, Last  | )  |                                 |   | 18. Mother's Name (   |   |  |  |
| Ŋ                   |   | 2                         | Alfred Baker  | Tuno Print)  | 10h Mail                        | in a Address (Street  | Catherine   | France                                      |  | Zin Cada)  |
|                     | 5 = 2 = 1   |                           | 19a. Informant's Name/Relationship (<br>Joanna Baker (Wife  |  |                                 |   | and Number or Rural F<br>. Road, Bal                            |   |  |  |
| ore,                | of Health<br>of Health<br>litem 27  |                           | 20a. Method of Disposition  1 XXurial 2 ☐ Cremation 3 ☐   | 2  |                                 | osition (Name of<br>matory or other place                     |   |   | c. Location - City or                        |  |
| Baltimore,          | permit. Pages<br>Department of<br>Importent: If It<br>any injury or c   |                           | * 4 □ Donation 5 □ Other (Speci   | N N  | Gardens                         |   |   |   | altimore,                                    |  |
| Ba                  | permit<br>Depar<br>Impor<br>any in  |                           | 21. Signature — eneral service Lice   | nsee   | 2                               | 2. Name and Addre<br>Br                                       | ss of Eacility<br>UZOZINSKI ]<br>Factory Ave                    | Funeral                                     | Home, P.                                     | A<br>yland 21221                                 |
| -                   | -   | -                         | 23a. Part1, Enter the disease, or comshops, or heart failure. List only                                     | plications that caused the   |                                 |   |   |   |  | Approximate<br>Interval Between                  |
|                     | Pnysician   |                           | Immediate Cause (Final  | NON SMALL  | CELL W                          | ung can   | susp  |   |  | Onset and Death                                  |
|                     | /Medical<br>Examiner  |                           | dise fe or condition<br>resulting in death)   | Due to (or as a co   | onsequence of):                 | ~   | - 0.1   |   |  | 210  |
|                     |   | e                         | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | b. Due to (or as a co  | onsequence of):                 | ane in  | monthy  | astret                                      |  | SYCHANS  |
| 18.                 | cuted<br>nd<br>ransit   | Examiner                  | cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last             | · Purnon   | MY GN                           | Bolism  | $\wedge$  |   |  | 1 month  |
| 30,7                | cate be executed<br>physician and<br>the burial-transit   |                           | resulting in death) Last  | Due to (or as a co   | onseque ce of):                 |   |   |   |  |  |
| 68760,              | tificate t<br>ig physical<br>as the b   | edical                    | •   | d  |                                 |   |   |   |  |  |
| P.O. Box (          | requires that the death certificate be executed signed by the attending physician and hould be detached for use as the burial-transit | Completed by Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                     | 23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at time 9 Unknown                  | Fetal death 3                   | □Ectopic pregnancy<br>□ Other (specify)                       | /   |   | 23d. Date of de<br>Month                     | livery<br>Day Year                               |
|                     | es that igned by  | y Ph                      | Part II. Other significant conditions   | contributing to death but no   | ot resulting in the             | ınderlying cause gıv  | ren in Part I.  | 23e. Did tobac                              | cco use contribute to                        | the cause of death?                              |
| ords                | w require<br>been sig<br>should b   | ted k                     | ANTIMA of   | afronc (   | DISTINE                         |   |   | 1 🗆 Yes                                     | 2 No 3 P                                     | robably 4 Ukknown                                |
| I Records,          | The law<br>ate has b<br>page 2 si   | Comple                    | DIABOTES  | Mellitus   |                                 |   |   | 24a. Was an autopsy performe                | prior to death?                              | utopsy findings available completion of cause of |
| Vital               | Physician: Th<br>this certificate<br>al director, pag   | Be                        | 25. Was case referred to medical examiner?  | Hospital:  |                                 | oth Oth   | 26. Place of Death (  |   |  |  |
| ō                   | Phys<br>this<br>ral dii   | T: To                     | 1 Yes 2 No  | 28a. Date of Injury  | 2 ER/Outpatie                   | of 28c. Injur   | v at 280  | 5 🗀 Residend  Describe how                  | ce 6 Other (Spe<br>injury occurred           | cify)  |
| ion                 | Attending I<br>r death.<br>ector: After<br>by the funer   | ation                     | 1 ☐ Matural 5 ☐ Pending investigation   |  | nar) Injury                     | M 1 🗆   | k?<br>Yes 2 □ No  |   |  |  |
| Division of         | To the Hospitel or Attendi<br>within 24 hours after death.<br>To the Funerel Director: A<br>completely filled in by the fu            | Certification:            | 3 Suicide 6 Could not be determined   |  | - At home, farm, si<br>Specify) | reet, factory, office   | 281   | Location (Stree<br>City or Town, S          | et and Number or R<br>State)                 | ural Route Number,                               |
|                     | he Hospi<br>in 24 hour<br>he Funer<br>pletely fill  | edical                    | 29a. Certifier 1 Certifying Pl<br>(Check only one) 2 Medical Exec   | nysician: To the best of m<br>miner: On the basis of exa<br>and manner stated            | amination and/or is             | th occurred at the tir<br>nvestigation, in my o               | me, date and place, and<br>pinion, death occurred               | d due to the caus<br>at the time, date      | se(s) and manner as<br>and place, and due    | s stated.<br>e to the cause(s)                   |
|                     | With<br>To 1  | Σ                         | 29b. Signature and title of certifier   | hom  | PHYSICIA                        | 29c. Licens   | ov64555   | 29d   | Date signed (Mont                            | 2007   |
|                     | ax1   |                           | 30. Name and address of person who  | completed cause of death   | (Item 23a) (Type                | Print)  | - A F HAS   | 21201                                       |  |  |
|                     | Sta   | te                        | 31. Date filed (Month, Day, Year)   | 3 Ragistrar's  | Signature -                     | 1715417   | www wy  | CINI  |  |  |
|                     | Registr   |                           | AUG 1 4 20  | 107 Herena   | N Ap                            | and I   |   |   |  |  |
| DH                  | MIL 47 D 4 (0)  | 201                       | 1100  |  |                                 |   |   |   |  |  |

DHMH 17 Rev 1/2001

Registrar

07-06085 Clayton Blakey

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| layton Blakey   |                | State of Maryland / Department of Health and Mental Hy  1-For State  Certificate of Death  |                                  | eg. No. 200                               | 7 2600                                    |
|---|----------------|--|----------------------------------|---|---|
| Physici   | an/            | 1. Decedent's Name (First, Middle,Last)  | 2. Date of Deat                  | h :                                       | 3. Time of Death                          |
| ledical Exami   | ner            | Clayton Jason Blakey  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death   | Month<br>August 8,               | 2007<br>4c. County of Deatl               | 1253 hrs                                  |
| *   |                | University Hospital  Baltimore City  |                                  | 4c. County or Deati                       | 1   |
| Funeral<br>Director   |                | 5. Social Security Number 214-29-7589 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.  | _                                | th (MM/DD/YYYY) 9. Bir<br>Foreig<br>1990  |   |
| any   |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |                                  |   | 10d. Inside City Limits                   |
| <u>*</u> .  | ŗ              | Maryland Baltimore   |                                  |   | 1 X Yes 2 No                              |
| Maryland<br>28a-f show<br><u>d at once,</u>   | Director       | 10e. Street and Number 10f. Zip Code   | 10                               | 0g. Citizen of What Cou                   | ntry?                                     |
| ith the<br>23a or<br>notifie  |                | 442 Augusta Avenue 21229  11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp   |                                  | USA                                       |   |
| n, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.  | Funera         | 11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. 14. No.)  14. Was Decedent of Hispanic Origin? (Sp. 15. No.)   | ecity Yes or No-<br>Rican, etc.) | - 14. Race - Amer<br>White, etc.          | ican Indian, Black,                       |
| after or ral", o  | by F           | 3 Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:  |                                  | Specify: Bla                              |   |
| 2 hours<br>"natu  |                | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the property of the control of the property of the prop |                                  | 16b. Kind of Business/                    | Industry                                  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the <u>Medical</u>  | ompleted       | 9 Student  |                                  | High Sch                                  | 1001                                      |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than  | ဝင္ပ           | 17. Father's Name (First, Middle, Last)  18. Mother's Name  Olivery 1 and 1 an | •                                | Maiden Surname)                           |   |
| 212<br>wild be<br>Menta<br>marke  | O B            | Charles Blakey Vanas  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or R  | sa Shaw<br>Rural Route Num       | nber, City or Town, State                 | , Zip Code)                               |
| MD<br>d 2 shc<br>lith and<br>n 27 is<br>aumati  |                | Charles Blakey - Father 442 Augusta Avenue;  | Baltimo:                         | re, MD 2122                               | .9  |
| ore,<br>es l an<br>of Hea<br>If iter  |                | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date                             | 20c. Location - City or                   | Town, State                               |
| Baltimore,<br>permit. Pages I ar<br>Department of Hee<br>Important: If ite  |                |  |                                  |   | e, Maryland                               |
| Ba<br>Depa<br>Depa<br>Impo  |                | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility Stering Funeral Home of Ca 1630 Edmondson Aver   | tonsViI<br>nue: Ca               | le, Inc.<br>tonsville.                    | MD 21228                                  |
| Physician<br>/Medical   |                | 23a. Part I. Enter the diseast or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.   |                                  |   | Approximate Interval<br>Between Onset and |
| Examiner  |                | Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):  |                                  |   | Death                                     |
|   |                | Sequentially list conditions,  b   |                                  |   |   |
|   | iner           | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause  |                                  |   |   |
| 1/2 g . (1/   | Examiner       | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):   |                                  |   |   |
| 60, ate be executed by sician and e burial - fransit  | Medical        | UNPENDED AMENDED   |                                  |   |   |
| Box 68760,<br>e death certificate be exe<br>the attending physician a<br>ed for use as the burial -   | /Med           | IF FEMALE: 23c. If yes, outcome of pregnancy   |                                  | 23d. Date of deliver                      | <u></u>                                   |
| certification   | sician/I       | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)  | ncy                              | Month                                     | Day Year                                  |
| Box<br>e death<br>the atte  | ا≲             | 1 Yes 2 No 9 Unknown 9 Unknown   |                                  |   |   |
| ires that the signed by   | by P           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                                  | bacco use contribute to                   |   |
| ds, lequires  | eted           |  | 24a. Was a                       | HARRIES                                   | utopsy findings available                 |
| ecor<br>e law r<br>te has b<br>ge 2 sh  | Completed      | ·  | autop:<br>perfor                 | med? death?                               | completion of cause of                    |
| ital Recionary The certificate rector, page   | Be Co          | 25. Was case referred to medical 26.Place of Death (Check of D | 1 ✓ Yes :                        | 2 No 1 Y                                  | es 2 No                                   |
| F Vita  | To B           | 114165 2 110   |                                  | Residence 6 Othe                          | r:  |
| ion of<br>tending Pheath.<br>or: After<br>the funeral   |                | 1 Natural 5 Pending Aug 8, 2007 1217 hrs 1 Yes 2 No  | Subject drivi                    | now injury occurred<br>ing motorscooter i | n collision with                          |
| Vision Atterdea   | ficat          | 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.  |                                  | Street and Number or Ru                   | ıral Route Number, City                   |
| Divers at meral D   | Certification: | 4 Homicide determined (Specify) Local Street   | or Town, Si<br>100 South Col     | tate)<br>llins, Baltimore, Md.            |   |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | Medical        | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.  |                                  |   |   |
|   | ž              | 29b. Signature and little of certifier 29c. License number   |                                  | 29d. Date signed (Mo                      | nth, Day, Year)                           |
| ~   | }              | 30. Name and address of person who completed cause of death (Item 23a)   |                                  | August 9, 2007                            |   |
| Ø   |                | Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212  | 201                              |   |   |
| St<br>Regist  | ate<br>rar     | 31. Date filed (Month, Day, Year) AUG 1 4 2007  33 Registrar's Signature   |                                  |   |   |
|   |                |  |                                  |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4b par doc 870 8-14-07 yt. State of Marylane? Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)

|                     | Physici<br>/Medic  |                | Richard Wallace  |  | Bapist                     | e11e                 | er  |  | August                                     | 2, Day                  | 2007 <sup>Year</sup>                                | 5:55p M  |
|---------------------|--|----------------|--|--|----------------------------|----------------------|---|--|--|-------------------------|---|--|
|                     | Examir   |                | 4a. Facility Name (If not institution, gives 5927 Johnnycake             |  | _                          | 4                    | 4b. City, Town, o <b>Balting</b>          | r Location of Dea                      | th   |                         | county of Death                                     |  |
|                     | Funeral  |                | 5. Social Security Number 6. 5   |  | n yrs. last birt           | hday)                | If Under 1 Year                           | If Under 24 Hrs                        |  | h                       | 9. Birtho   | lace (State or Foreign                         |
| l                   | Director   |                | 218-42-5878 Usual Residence of Decedent                                  | 1 ₹ M 2 □ F  | 62                         | rs.                  | Months Days                               | Hours Min                              |  |                         | 945 Mary  |  |
|                     | land<br>ow<br>at   |                | 10a. State 10b. County   | 10   | c. City, Town              | or Loca              | tion                                      |  |  |                         | 1   | 0d. Inside City Limits                         |
|                     | Man<br>a-f sh<br>ified   | ż              | MD Baltimo   | ore  |                            | Ba1                  | timore                                    |  |  |                         |   | 1 ☐Yes 2 No                                    |
|                     | ith the<br>or 28<br>e not  | Director       | 10e. Street and Number   |  |                            |                      | 10f. Zip Code                             |  |  | 10g. Citize             | en of What Cour                                     | try?   |
|                     | ath w  | ral            | 5927 Johnnycake  |  |                            | l                    | 21207                                     |  |  | U.S.A                   |   | 1.00   |
|                     | ter de<br>Item:<br>Iner n  | Funeral        | 11. Marital Status  1 ☐ Never Married 2 ☐ Married                        | 12. Was Decedent Eve<br>Armed Forces?<br>1 ☐ Yes 2 ☑ No                | r in U.S.                  | 13. Wa               | as Decedent of F<br>res, specify Cub      | lispanic Origin? (<br>an, Mexican, Pue | Specify Yes or No-<br>nto Rican, etc.)     | 14                      | <ol> <li>Race - Americ<br/>Black, White,</li> </ol> |  |
| 20                  | urs af<br>al", or<br>Exam  | by             | 3 Widowed 47 Divorced  | If Yes, Give X<br>Year or Dates:                                       |                            | 1[                   | ∐Yes 2∏ No                                | Specify:                               |  | 5                       | Specify: whit                                       | .e   |
| ה<br>ה              | 72 ho<br>natur<br>dicai I  | eted           | 15. Decedent's E<br>(Specify only highest gr                             | ducation .<br>ade completed)   | 16a.                       | Decedei<br>(Give kii | nt's Usual Occup                          | ation<br>during most of we             | orkina I                                   | 16b. Kind               | d of Business/Inc                                   | dustry   |
| 7                   | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.  is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at  | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5+)   | - 1                        | ife. DC<br>.nte1     |   | during most of wo<br>d)                |  | Prin                    | +ina  |  |
| 20                  | filed v<br>Hygie<br>ther 1   |                | 17. Father's Name (First, Middle, Las                                    | <u>         3                           </u>                           | 11.                        | -1100                | L   | 18. Mother's Na                        | me (First, Middle,                         |                         |   |  |
| Maryland 21215-0036 | ild be<br>lental<br>ked o  | To Be          | George Bapistell   | ler  |                            |                      |   | Betty                                  | June Ste                                   | wart                    |   |  |
| ary                 | shou<br>and N<br>s mar   |                | 19a. Informant's Name/Relationship                                       | (Type. Print)  | 19b.                       | Mailing              | Address (Street                           | and Number or F                        | Rural Route Numbe                          | er, City or             | Town, State, Zip                                    | Code)  |
|                     | D = 1 = 0  |                | Chris Bapistelle   |  |                            |                      |   | nue Balt                               | imore MD                                   |                         |   |  |
| 0                   | Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show arty or other traumatic event, the Medical Examiner must be notified at |                | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐                  |  | 20b. Place of<br>Lake \    | Disposit<br>Lew      | ion (Name of<br>itory or other pla<br>Mem | ark 8-6                                | Date -2007                                 |                         | ation - City or To                                  | wn, State<br>Maryland                          |
| baltimore,          | permit. Pages 1 an<br>Department of Heal<br>Important: if item 2<br>any injury or other<br>once.   |                | 4 ☐ Donation 5 ☐ Other (Special Signature of Fune 1) Service Lice        |  |                            | 22.1                 | Name and Addre                            | ss of Facility                         |  | Dyke                    | sville,   | ralyland                                       |
| g                   | permit. Departr Importa any inju   |                |  | 110.00   |                            | 1 Amb                | MACO En                                   |  | me, Inc.                                   |                         | ND 040  | 0.7  |
| ľ                   |  |                | 23a. Part1. Enter the disease, or con shock, or heart failure. List only | nplications that caused the  | e death. Do n              | ot enter             | the mode of dyir                          | U <b>r Sprin</b><br>ng, such as cardia | ig Rd. Ar<br>ac or respiratory ar          | butus<br>rest,          | <del>3 MD-21</del> 2                                | pproximate<br>Interval Between                 |
|                     | Physician  |                | disease or condition   | Luna (   | Cance                      | -                    |   |  |  |                         |   | Onset and Death                                |
|                     | /Medical<br>Examiner   |                | resulting in death)  | Due to (or was co  |                            | -                    |   |  |  |                         |   |  |
|                     | LAMIIIIEI  | <u>_</u>       | Sequentially list conditions, if any, leading to immediate               | b. Due to (or as a co  | onsequence o               | ıf\·                 |   |  |  |                         |   |  |
| 8                   | uted<br>Insit  | Examiner       | Cause (Disease or injury   | Due to (or as a co   | onocquence c               |                      |   |  |  |                         |   |  |
| oʻ                  | exection and and rial-tra  |                | that initiated events<br>resulting in death) Last                        | Due to (or as a co   | onsequence o               | of):                 |   |  |  |                         |   |  |
| 200                 | eath certificate be executed<br>attending physician and<br>for use as the burial-transit   | ical           |  | d  |                            |                      |   |  |  |                         |   |  |
| J. BOX 68/60,       | ertifica<br>ling pl  | Med            | IF FEMALE:   | 000 16   |                            |                      |   |  |  |                         |   |  |
| o                   | death certificate be executed<br>e attending physician and<br>of for use as the burial-transii   | sician/Medical | 23b. Was decedent pregnant in the past 12 months?                        | 23c. If yes, outcome pf p<br>1 ☐ Live birth 2 ☐<br>4 ☐ Pregnant at tim | Fetal death                | 3□E<br>5□ 0          | ctopic pregnanc<br>Other (specify) _      | /                                      |  | 23                      | 3d. Date of delive<br>Month                         | ery<br>Day Year                                |
| ٠.                  | t the de<br>by the a   | Physi          | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 9□Unknown  |                            |                      | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,   |  |  |                         |   |  |
| S,                  | w requires that the<br>been signed by the<br>should be detach  | by P           | Part II. Other significant conditions                                    | contributing to death but n  | ot resulting in            | the und              | erlying cause giv                         | en in Part I.                          |  |                         |   | ne cause of death?                             |
| 000                 | requir<br>een s<br>nould   | ted            |  |  |                            |                      |   |  | 12   | ′es 2□                  |   |  |
| Vital Records,      | has b  | Completed      |  |  |                            |                      |   |  | 24a. Was<br>autop                          |                         | dooth?  | psy findings available<br>mpletion of cause of |
| ū                   | in: Th<br>ificate<br>or, pag   |                | 25. Was case referred to medical   |  |                            |                      |   | 00 Pl f P-                             | 1□ Yes                                     | 2 No                    | 1 ☐ Yes   | 2 No   |
|                     | ysicia<br>is cert<br>directo   | o Be           | examiner?  | Hospital:  | 2 ☐ ER/Qu                  | patient              | 3□ DOA Oth                                | or                                     | eath <i>(Check only o</i><br>Home 5 PResid |                         | Other (Specif                                       | iv)  |
| DIVISION OF         | ng Ph<br>fter thi  | n: T           | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending                              | 28a. Date of Injury<br>(Month, Day Ye                                  | 28b. T                     | ime of<br>ijury      | 28c. Inju                                 |  | 28d. Describe h                            |                         |   |  |
| SIO                 | tendii<br>eath.<br>tor: A<br>the fu  | catic          | 2 Accident investigation 3 Suicide 6 Could not be                        | n  |                            |                      | M 1 🗆                                     | Yes 2 No                               |  |                         |   |  |
| $\leq$              | or At<br>after d<br>Direct<br>in by  | Certification: | 4 Homicide determined  |  | - At home, fai<br>Specify) | m, stree             | t, factory, office                        |  | 28f. Location (8<br>City or Tox            | Street and<br>n, State) | Number or Rura                                      | l Route Number,                                |
|                     | To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detache                    |                |  | hysician: To the best of r   | ny knowledge               | , death o            | occurred at the ti                        | me, date and plac                      | ce, and due to the                         | cause(s) a              | and manner as s                                     | tated.   |
|                     | he Ho<br>in 24 h<br>he Fu<br>pletely   | Medical        | (Check only 2 Medical Exa  | miner: On the basis of ex<br>and manner stated                         |                            | d/or inve            | stigation, in my                          | opinion, death oc                      | curred at the time,                        | date and I              | place, and due to                                   | o the cause(s)                                 |
|                     | To t<br>To t   | Σ              | 29b. Signature and title of certifier                                    | ( MD   |                            |                      | 29c. Licens                               | e number                               |  | 29d. Date               | signed (Month,                                      | Day, Year)                                     |
|                     |  |                | Mulai  |  |                            |                      | 200                                       | 0002                                   |  | 8/.                     | 3/200   | <i>t</i>                                       |
|                     | 5  |                | 30. Name and address of person who                                       | completed cause of death   | h (Item 23a) (<br>I kens   |                      | int) Balt                                 | 8662<br>more,                          | MD 2                                       | 122                     | 9   |  |
|                     | Sta  | ite            | 31. Date filed (Month, Day, -Year)                                       | 32. Registrar's  |                            | - 17 -               |   | ,                                      |  |                         | •   |  |
|                     | Registi  | ar             | AUG 1 4  | 2007   | N.                         | A                    | call o                                    |  |  |                         |   |  |
| DH                  | IMH 17 Rev 1/2   | 001            |  |  |                            | ORIG                 | ΙΝΙΔΙ                                     |  |  |                         |   |  |
|                     |  |                |  |  |                            | Uniu                 | 111 Y/\L                                  |  |  |                         |   |  |

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ "any injury or other traumatic event." **Physician** /Medical Examiner Examine attending physician and for use as the burial-tran Physician/Medical Completed by Be Certification: To ours after death.

neral Director: A
filled in by the fu within 24 hours a

To the Funeral C

completely filled Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 154352 AUGUST 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITTER TODOR NORTHWEST HOSPITAL 5401 OLD COURTROAD RANDAUSTOWN 21133 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 9 per fb 9870 8-14-07 vt

State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Carter charles 1230 PM August 7007 O /Medical 4c. County Examiner of Death ussing a Himare If Under Months 9. Birthplace (State or Foreign Country) **Funeral** Hours Director of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Tewn or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 Pres 2 No Be Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? Was Decedent Ever in U.S Armed Forces? Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working nit. Pages 1 and 2 should be filed within 72 ho artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natur injury or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) Elementa (7) Secondary (0-12) College (1-4or 5+) er's Name (First, Middle 18. Mother's Name (First, Middle, Maiden Surname 2 Baltimore, Method of Disposition 1 Burial 2 □ Cremation 3 DRemoval from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 21. Signature he disease, or complications that caused the death. Do not enter the mode of int failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Athero scheolic hysician Cevebral v93cula y fours /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Physician/Medical Examiner One to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2. No Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 250 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1- Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 037573 13,2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reisterstaun Mais MD 25 MD 21136 Ciloel1 31. Date filed (Month, Day, 32. Paistrar's Signature Year) State

Registrar

AUG 1 4

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 200 T **Physician** Month 12:49A.M DRUCE d /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. Months 1 M 2 □ F Director 10/21 OH Tavenna, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at Bel 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Whit þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 6b. Kind of Business/Industry burdeer Elementary/Secondary (0-12) 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental traumatic ပ္ 101 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any inJury or other tr hiles 1409 200K Drier 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐Removal from State 10107 22. Name and Address of Facility Que port 21. Signature of Funeral Service License Forest Hill, MD Sombell Evans Funeral Chapel 23a. Part1. Enter the disease, or complication; hat caused the death. Do not enter the mode of dying, such as cardiac or re-piratory arrest, shock, or heart failure. List only one cars, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** laRu of montas /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a detached f 9□Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has autopsy perform Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending (Month, Day Year) Injury 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation 24 hours after deatl 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29b. Signature and title of certifie 29c-License number 29d. Date signed (Month, Day, Year) 58 2007

Registrar

State

31. Date filed (Month

No

6701

32 Registrar's Signature

Marles Stacks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES

Year)

COLUMBIA

Hours

If Under 1 Year | If Under 24 Hrs.

20723

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Days

10f. Zip Code

1 ☐ Yes 2 ☑ No

HOSPITAL

10c. City, Town or Location

Laurel

7. Age (In yrs. last birthday)

52

COUNTY GENERAL

1 ☑ M 2 ☐ F

6. Sex

Howard

1745

10d. Inside City Limits

Approximate Interval Betwee Onset and Dea

DAYS

Day

Year

Month

1 ☐ Yes 2 ☑ No

Birthplace (State or Foreign Country)

HOWARD

May 23, 1955 Washington, DC

10g. Citizen of What Country?

USA

14. Race - American Indian Black, White, etc.

White

8. Date of Birth (Month, Day, Year)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 200 or 200

**Physician** 

/Medical

Examiner

Director

**Funeral** 

Director

HOWARD

10a. State

5. Social Security Number

578-62-4842

10e. Street and Number

11. Marital Status

Usual Residence of Decedent

10h County

10705 Graeloch Road

PETA-CAY JACKSON BOOTH

31. Date filed (More, Day, Year)

1 Never Married 2 Married

Physician /Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed Director: /

Box 68760.

Division or Vital Records, P.O.

ģ Completed Be P Certification: hours after within 24 hours at To the Funeral D Medical

Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th 4 Director Industrial Hygiene 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Avery Christopher ပ Helen Mae 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Ann Lewis/Wife 10705 Graeloch Road, Laurel, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 8/20/2007 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Sign of F neral Cervice Life M00773 313 Talbott Avenue, Laurel, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause ( al disease or condition resulting in death) METASTATIC MELANOMA Due to (or as a consequence of): METABOLIC ACIDOSIS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? LEFT LOWER EXTREMITY DEEP VENOUS THROMES IS 1 Yes 2 No 3 Probably 4 Winknown ANEMIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy THROM BOCYTOPENIA 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural (Month, Day Year) 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number PHYSICIAN D52022 AUG 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

32. gistrar's Signature

5755 CEDAR LANE, COLUMBIA, MD 21044

07-06107

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Bret M Conn 2007 26012 Certificate of Death 1- For State Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day August 9, 2007 0624 hrs Medianal Examiner Maro1t Conn Bret 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Carroll Sykesville Springfield Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Foreign Washington Months Hours Davs Director 1982 Aug 11, 1 X M 2 F 24 218-04-2237 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 X No 28a-f show Sykesville s 23a or 28a-f shov n tified at once Carrol1 Maryland| Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21784 6655 Sykesville Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12: Was Decedent Ever in U.S. Funeral White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces 1 X Never Married 2 Married Yes 2X No Specify: White ges I and 2 should be filed within 72 hours after of Health and Menial Hygiene.
If item 27 is marked other than "natural" on If Yes, Give Year Yes 2 X No specify: 4 Divorced Widowed ð 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 Wood Flooring Installer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maro1t Cathy event, Be Kenneth R. Conn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) <u>Q</u> Maryland 21045 Columbia, 6389 Wind Harp Way Kenneth R. Conn/father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Odenton, Maryland West Arundel Crematory 8/14/2007 Other Specify: Donation 5 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 21 Signature of Funeral Service Licensee Himao rt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and lure. List only one cause on each line. **fedical** a. Hanging Immediate Cause (Final disease .aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED physician the burial -A#ENDED 27, 28a-f, perME, g871, 9/25/07 TT Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death use as t 2 past 12 months' Pregnant at time of death 5 Other (Specify) ned by the atter detached for u Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. P.O. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 V Unknown þ Completed 24b. Were autopsy findings available Records, 24a Was an prior to completion of cause of autopsy has death? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) the Hospital or Attending Physician: director, 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Hospital: 1 examiner's Residence 6 V Other: Scene Nursing Home 5 FR/Outpatient 3 Inpatient 2 this 1 V Yes 2 No After th 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death Certification: 1 Yes 2 X No Natural Pending subject hanged self FNd 8.9.2007 Fnd 6:00 am the Funeral Director: npletely filled in by the Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 X Suicide Could not be 6655 Sykesville Rd. Sykesville, MD (Specify) Springfield State Hospital Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 10, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

State Registrar

Theodore M. King, Jr., MD.

4

31. Date filed (Month, Day, Year)

**ORIGINAL** 

OSSA

Assistant Medical Examiner Registrar's Signature

111 Penn Street, Baltimore, MD 21201

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Doris B. Carlson August 2 2007 9:40 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 84 Director 238-10-8926 25, 1923 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Montgomery Rockville 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9807 Viers Drive #1 20850 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **X**No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify. ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I any Injury or other traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) Clerk Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pierce Franklin Butler Myrtle Lefler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig Carlson- Son 3091 Will Mill Road, Monrovia, MD 21770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-9-2007 Brentwood, MD Fort Lincoln Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tri 1040 Rockv Rockville, MD e 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Esophageal Perforation Days /Medical Due to (or as a consequence of): Examiner Espophageal Stricture Sequentially list conditions, if any, leading to in-modate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Months Due to for as a consequence of Examine Many Years and burial-trai Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: P 1 ☐ Yes 2 🙀 No 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 XNatural 2 ☐ Accident (Month, Day Year) 5 Pending Injury after death.

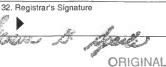
Director: Af 1 □ Yes 2 □ No investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

Box 68760.

Division or Vital Records, P.O.

State Registrar

31. Date filed (Month, Day, Year)



Robert M. Eisdorfer, MD, 15001 Shady Grove Road, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19a per inf 88/1 9-18-07 vt State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ionisic /Medical 4c. County of Death vn, or Location of Death Examiner Medica. THORE TIMORE enter If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. 1 M 2 □ F Months Hours Yrs Director 081-32-8469 June 09, 1936 Puerto Rico Usual Residence of Decedent death with the Maryland 10a. State if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itema 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Baltimore Windsor Mill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3641 Langrehr Road 21244 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 GYes 2 No
If Yes, Give
Year or Dates: Korean 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Yes 2□ No Specify: Puerto Rican Specify: Hispanic à 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Postal Service Letter Carrier 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Juan Castro Alejandrina Martinez 2 19a. Informant's Name/Relationship (Type, Print) Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 3641 Langrehr Road, Windsor Mill, Maryland 21244

20b. Place of Disposition (Name of cometery, crematory or other place)

Date 20c. Location - City or Town, State Ms. Benita Figueroa 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garri Garrison Forest Veterans Cem 08/14/07 Owings Mills, MD 21117 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Funeral Service Licensee . Kellner 100333 23a. 7611. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 8728 Liberty Road, Randallstown, Maryland 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, larry leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conservamos of Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 No 1 Yes 1 ☐ Yes 2 No Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death Check only one examiner' Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) lospire. 4 hours after dearn. Funeral Director; After this of the funeral d 2 R/Outpatient 3 DOA this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the bast of my knowledge death occurred at the time, date and clade and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) ţ, and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Va MI cause of death (Item 23a) (Type, Print) MP 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year James Connolly 936 PM 07 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** enal medical Centre If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 X M 2 □ F 900-31-5776 63 Director Oct 24, 1943 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at MD Wicomico 1 ☐ Yes 2 No Director Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code raf", or items 23a or Examiner must be 233 Ohio Avenue Funeral 21801 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify Specify: 3 ☐ Widowed 4 ☒ Divorced "natural", white Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) carpenter self employed unk Department of Health and Mental Hygie Important; if item 27 is marked other tany injury or other traumatic event, the once. unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk James Sinagra/friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4□Donation 5▼Other (Specify) in state 21. Signature of Eureral Service Ucer State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part Enter the disease, or com shock or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COPD /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1旦Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 2 No within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 No Certification: To 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Marher of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 ☐ Pending investigation Injury 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signatu e and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 813102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

|              |  |                  | For<br>State<br>Registrar  | State of Marylar  |                     | artment of H<br>rtificate of L                                      |   |                                       | giene () () ()         | 26015   |
|--------------|--|------------------|--|---|---------------------|---|---|---------------------------------------|------------------------|---|
|              |  |                  | 1. Decedent's Name (First, Middle, La  | ast)  |                     |   |   | 2. Date of Dea<br>Month               | th<br>Day Yea          | 3. Time of Death  |
|              | Physici  |                  | Johnie Coad Sr.  |   |                     |   |   |                                       | 11 2007                | 01.52 M   |
| >            | /Medio<br>Examin   |                  | 4a. Facility Name (If not institution, gir                                   | ve street and number)                                   |                     | 4b. City, Town, or  | Location of Deatl                       | h                                     | 4c. County of De       | eath  |
| •            |  | •                | Calvert County Hospi   | tal   |                     | Prince Fre  | ederick                                 |                                       | Calvert                |   |
| T            | Funeral  |                  | 5. Social Security Number 6.   | Sex 7. Age (In yrs.                                     | last birthday       |   | If Under 24 Hrs.<br>Hours Min.          |                                       | 9. 1                   | Birthplace (State or Foreign                                  |
|              | Director   |                  | 229-30-1321  | 1XM 2□F   | 32 Yrs.             | Months Buys   | TIOUTO INIIII.                          | May 4, 19                             | 925                    | SC SC   |
|              | Pu ,   |                  | Usual Residence of Decedent  | 10- 0   | . T                 |   |   |                                       |                        | 10d. Inside City Limits                                       |
|              | be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural, or items 23a or 28a-f ehow other than "natural, or items 23a or 28a-f ehow event, it a Medical Exaction trust to notified at  | _                | 10a. State 10b. County   | 10c. CI   | ty, Town or L       | ocation   |   |                                       |                        | 1 Tes 2 No  |
|              | Ba-f   | cto              | MD St. Ma  | arys Cha  | arlotte             |   |   |                                       |                        |   |
|              | ith th   | Funeral Director | 10e. Street and Number   |   |                     | 10f. Zip Code   |   |                                       | 10g. Citizen of What   | Country?  |
|              | 23a  | a                | 29449 Charlotte Hall   | <del></del>   |                     |   | 622                                     |                                       | USA                    |   |
|              | r de   | ne               | 11. Marital Status   | 12. Was Decedent Ever in L<br>Armed Forces?             | I.S. 13.            | Was Decedent of Hi<br>If Yes, specify Cuba                          | ispanic Origin? (S<br>n, Mexican, Puerl | specify Yes or No-<br>to Rican, etc.) | Black, Vy              |   |
| 9            | or it  | Ę.               | 1 Never Married 2 XMarried   | XX Yes 2 □ No<br>If Yes, Give                           |                     | 1 ☐ Yes 2X No   | Specify:                                |                                       | Specify,               | irican-   |
| 2-0030       | ural',   | d by             | 3 Widowed 4 Divorced   | Year or Dates:  | 1                   |   |   |                                       | Specify Ame            |   |
| ပု           | nat<br>nat   | Completed        | 15. Decedent's E<br>(Specify only highest g                                  | ade completed)  | (Give               | edent's Usual Occupa<br>e kind of work done o<br>DO NOT use retired | during most of wo                       | rking                                 | 16b. Kind of Busine    | ss/moustry  |
| Z            | Athir<br>han   | Ē                | Elementary/Secondary (0-12)  | College (1-4or 5+)                                      | Labore              |   | ,                                       |                                       | Sparrows Poi           | nt  |
| N            | filed<br>Hygie<br>Sther<br>ant,  |                  | 17. Father's Name (First, Middle, Las  | r)  | Lawre               | <u>aL</u>   | 18. Mother's Nar                        |                                       | Maiden Sumame)         | 110   |
| and          | uld be 1<br>Aental I<br>rrked o  | Be               |  | •   |                     |   | Sallie Ma                               | _                                     | ,                      |   |
| 5            | 2 should<br>and Men<br>is marke  | 2                | George Coad  19a. Informant's Name/Relationship                              | (Tuna Brint)  | 10b Mail            | ing Address (Street   |   |                                       | or, City or Town, Stat | a Zin Codel   |
| 2            | CA 40 = 4  |                  | John L. Coad Jr., /So  |   |                     | wondale Rd.   |   |                                       |                        | o, 21p 0000)  |
| d)           | s 1 and<br>if Health<br>item 27<br>other ti  |                  | 20a. Method of Disposition   |   | -                   | osition (Name of  |   | Date                                  | 20c. Location - City   | or Town, State  |
| saitimore    | permit. Peges: Department of H importent: if ite any injury or ot  |                  | 1 ⊠ Burial 2 ☐ Cremation 3   | Removal from State                                      | cemetery, cre       | matory`or other plac  | 8-16-                                   | Î                                     | Owings Mills           |   |
|              | t. Pertrant  |                  | 4 Donation 5 Other (Spec   |   |                     | orest Vet.  |   |                                       | of Baltimor            |   |
| a<br>a       | Depariment of the population o |                  | 21. Signiture of Funeral Service Lice  | ensee // ////   |                     | 200 Liberty 1   |   |                                       |                        | c dailey  |
|              | 40290  |                  | praidelle  | In. Wyu   |                     |   |   |                                       |                        | Approximate   |
|              |  | 12               | 23a. Part 1. Enter the disease, or cor<br>shock, or heert failure. List only | y one cause on each line.                               |                     |   | -                                       | 27 1                                  | 1                      | Interval Between<br>Onset and Death                           |
|              | Physician  | V                | Immediate Cause (Final disease or condition                                  | Intra   | Cere                | bral  | Blee                                    | ting /                                | CVA                    |   |
|              | /Medica!<br>Examiner   |                  | resulting in death)  | Due to (or as a conse                                   | quence of):         |   |   | 0                                     |                        | 8/6/07  |
|              | LAMITHIE   |                  | Sequentially list conditions,  | b   |                     |   |   |                                       |                        | 010104  |
| 7            | ם ב  | i e              | if any, leading to immediate cause. Enter Underlying                         | Due to (or as a conse                                   | quence of):         |   |   |                                       |                        |   |
| J            | acute<br>and<br>trans  | Examin           | Cause (Disease or injury that initiated events resulting in death) Last      | c   |                     |   |   |                                       |                        |   |
| Š            | e exe  |                  | 1030king in oddan Ladi   | Due to (or as a conse                                   | quence or):         |   |   |                                       |                        |   |
| 9/8          | certificate be executed uding physician and use as the burial-transit  | dicai            | •  | d   |                     |   |   |                                       |                        |   |
| Õ            | leath certifica<br>attending ph<br>I for use as th   | Z e              | IF FEMALE:   | 10.   |                     |   |   |                                       |                        |   |
| X<br>Q<br>R  | th ce  | Physician/Me     | 23b. Was decedent pregnant in the past 12 months?                            | 23c. If yes, outcome of pregr<br>1 ☐ Live birth 2 ☐ Fet | al death 3          | □Ectopic pregnancy  | ,                                       |                                       | 23d. Date of<br>Month  | delivery<br>Day Year  |
|              | 0 0 0  | Sici             | 1 ☐ Yes 2 ☐ No   | 4☐Pregnant at time of 9☐ Unknown                        | death 5             | Other (specify)   |   |                                       | , and the second       |   |
| J.           | ± ≥ 8  | F                | 9 Unknown  |   |                     |   |   | One Did to                            |                        | a to the server of death?                                     |
| Ś            | res that<br>igned to<br>be det   | ρ                | Part II. Other significant conditions  | contributing to death but not re                        | sulting in the      | ungerlying cause givi   | en in Part I.                           |                                       |                        | e to the cause of death?  Probably 4 Dunknown                 |
| Vital Record | w requir<br>been si<br>should  | Completed        |  | · · · · · · · · · · · · · · · · · · ·                   |                     |   |   |                                       |                        | //  |
| ပ္ထ          | as s   | pie              |  |   |                     |   |   | 24a. Was<br>autop                     | an 24b. Were           | autopsy findings available<br>to completion of cause of<br>n? |
| r            | E as ag  | ě                |  |   |                     |   |   | perfo<br>1 ☐ Yes                      | rmed? deati            | res No  |
| <u> </u>     | ician:<br>certifica<br>rector, p   | Be C             | 25. Was case referred to medical   |   |                     |   | 26. Place of De                         | ath (Check only o                     | ne                     | - (f)   |
|              | 8 E  | 2                | examiner?<br>1 □ Yes 2 No  | Hospital: 1 Inpatient 2                                 | ER/Outpatie         | ent 3 DOA Oth   | er: 4 Nursing 8                         | Home 5 ☐ Resid                        | dence 6 □Other (5      | Specify)  |
| Division of  | ng Ph<br>ter th  |                  | 27. Manner of Death<br>1™ Natural 5 ☐ Pending                                | 28a. Date of Injury<br>(Month, Day Year)                | 28b. Time<br>Injury | of 28c. Injur   | y at<br>k?                              | 28d. Describe I                       | now injury occurred    |   |
| Ö            | or Attending ufter death. Director: After in by the fune   | atic             | 2 ☐ Accident investigate   | on  |                     |   | Yes 2 □ No                              |                                       |                        |   |
| <u> </u>     | Attenar deat   | €                | 3 Suicide 6 Could not<br>4 Homicide determine                                |   | nome, farm, s       | treet, factory, office  |   | 28f. Location (S<br>City or Tox       | Street and Number o.   | Rural Route Number,   |
| 5            | s after<br>si Dire   | Certification:   |  | 50.1.d.l.g, 616. (5566                                  |                     |   |   |                                       |                        |   |
|              | Hospital     24 hours a     Funersi I  |                  | 29a. Certifier 1 Certifying F  | Physician: To the best of my kn                         | owledge, dea        | th occurred at the tin  | ne, date and plac                       | e, and due to the                     | cause(s) and manne     | r as stated.  |
|              | To the Hospital or within 24 hours after To the Funersi Dir completely filled in   | edicai           | (Check only 2 Medical Exp  | aminer: On the basis of examin<br>and manner stated.    | ation and/or        | ivestigation, in my o   | PHILOH, CHACH OCC                       |                                       |                        |   |
|              | To the within 2. To the complete   | Σ                | 29b. Signature an till of certilier  | 10may   | MO                  | 29c. Licens   | e number                                | 2                                     | 29d. Date signed (M    | onth, Day, Year)  |
| •            |  |                  |  | J 7   |                     | 1)00  | 1/100                                   | 7                                     | 8/12                   | 12007   |
| 1            | 121  |                  | 30. Name and address of person wh  | o completed cause of death (Ite                         | m 23a) (Type        | o, Print)   |   |                                       | 2                      | - A4A   |
| L            | 11,  |                  | ZAHIL  | WUSAF MD  |                     | YO B  | 0X 13                                   | 289 W                                 | ALDOR                  | F MI)   |
|              | Sta  | ate              | 31. Date filed (Month, Day, Year)  | 32 Hagistrar's Sign                                     | ature               | 0-0-  |   |                                       |                        | 20004   |
|              | Regist   | rar              | AUG 1 4  | 2007 Believe.   | S. A.               | DEALE)  |   |                                       |                        | /   |
| DH           | MH 17 Rev 1/2  | 001              |  | 3   |                     |   |   |                                       |                        |   |

07-06198 Jaron T. Denny Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2 Date of Death Time of Death Physician/ Month Day August 12, 2007 0216 hrs **Medical Examiner** Jaron Denny 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Forestville Inner loop 495 If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Foreign Virginia
Country) Months Days Hours 229-13-5220 Director Feb.19,1976 1 X M 2 31 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location Yes 2 X No 23a or 28a-f show Md. Prince Georges Forestville notified at once, the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 20747 USA 6711 Darkwood Court with t Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? death v 1 X Never Married 2 Married 2 X No. Yes 9 after Divorced If Yes Give Yea Yes 2 X No specify: Specify: Black matic event, the Medical Examiner "natural", 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry Completed during most-of working life. DO NOT use retired) timore, MD 21215-0036
i., Pages I and 2 should be filed within 72 hou timent of Health and Mental Hygiene.
rtant: If iten 27 is ongriked other than "na College (1-4 or 5+) Elementary/Secondary (0-12) Printing Co. 12 1 Printer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lorita Denny Harry Chester Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 2 2 0 4 19a. Informant's Name/Relationship (Type, Print) 750 S.Dickerson St.#414 Arlington, Va. Lorita Denny-Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a, Method of Disposition other tra Itimore, crematory or other place) 1 X Burial 2 Cremation 3 8/17/07 Falls Church, Va. Second Bapt.Church tant: Donation 5 Other Specify: 22. Name and Address of Facility Signature of Funeral Service License 2605 S.Shirlington Chinn Funeral Service Ar1.Va.22206 Road Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit executed Physician/Medical UNPENDED AMENDED ending physician use as the burial The law requires that the death certificate be Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Live hirth Fetal death past 12 months? Pregnant at time of death Other (Specify) med by the atte 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available certificate has been autopsy prior to completion of cause of performed' death? page No Yes 2 1 🗸 Yes 2 After this certifi-funeral director. 26 Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: of Vital Be examiner? Hospital: Other: DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 1 🗸 Yes ٩ 28a. Date of Injury (Month, Day Year) Aug 12, 2007 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: motorcyclist involved in auto accident 0205 hrs Division within 24 hours after death.

To the Funeral Director; A completely filled in by the fun 1 Natural Yes 2 V No Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) Inner loop 495, Forestville, MD determined (Specify) Interstate/Express Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie August 12, 2007 O.C.M.E. Jasse 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Manth Can Year) State 2007 Registrar

|                     |  |                  | For State Registrar  | State of M   | /larylan             |   | artment<br>rtificate                                |                               |                      | ınd Me                   |   | giene<br>Reg. No.            | 007  | 26018  |  |
|---------------------|--|------------------|--|--|----------------------|---|---|-------------------------------|----------------------|--------------------------|---|------------------------------|--|--|--|
|                     | Physic   |                  | Decedent's Name (First, Middle, Le  MARY DAVIS   | ,  |                      |   |   |                               |                      |                          | 2. Date of Dec<br>Month<br>August         |                              | 2007   | 3. Time of Death 10:10 a M                       |  |
|                     | /Medi<br>Examir  |                  | 4a. Facility Name (If not institution, gi<br>Harmony Hall Ass  |  |                      |   | 4b. City, To  | umbi                          | .a                   |                          |   |                              | unty of Death<br>ward                        | J  |  |
|                     | Funeral<br>Director  |                  |  | Sex 7. A<br>1 □ M 2 □ F  | Age (In yrs. I       | ast birthday)<br>Yrs.                   | If Under 1<br>Months (                              | Year<br>Days                  | If Under a           | Min.                     | 3. Date of Birt<br>(Month, Da<br>Tune 6 , | v, Year)                     | Cour   | place (State or Foreign<br>htry)<br>Sylvania     |  |
|                     | death with the Maryland<br>ms 23a or 28a-f show<br>r must be notified at   | tor              | 10a. State 10b. County MD Anne Ar  | undel  |                      | , Town or Lo                            |   |                               |                      |                          |   |                              | 10d. Inside City Limits<br>1  ☐ Yes 🎎 No     |  |  |
|                     | th with the<br>23a or 28<br>ist be not   | Funeral Director | 10e. Street and Number<br>1434 Fairfield L   | oop Road   |                      |   | 10f. Zip C  | ode<br>032                    |                      |                          |   | 10g. Citizen                 | of What Cour                                 | ntry?  |  |
| 9036                | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Midical Examiner must be notified at once.   | þ                | 11. Marital Status  1 □ Never Married 2 □ Married  *XXWidowed 4 □ Divorced   | 12. Was Deceder Armed Forces 1  Yes 21 If Yes, Give Year or Dates    | s?<br><b>X</b> No    |   | Was Deceder<br>f Yes, specify<br>1 □ Yes            |                               |                      | gin? (Spec<br>, Puerto R | ify Yes or No-<br>ican, etc.)             |                              | Race - Americ<br>Black, White,<br>ecify: Wh  |  |  |
| Maryland 21215-0036 | twithin 72 ho<br>piene.<br>r than "natu<br>the Medical   | Completed        | 15. Decedent's E<br>(Specify only highest gr<br>Elementary/Secondary (0-12)<br>Grade 12  | ducation<br>rade completed)<br>College (1-40                         | r 5+)                | 16a. Deced<br>(Give<br>life. I          | dent's Usual (<br>kind of work<br>DO NOT use<br>erk | Occupa<br>done di<br>retired) | tion<br>uring most   | of working               | 7   |                              | of Business/Ind<br>ware St                   | ·  |  |
| yland?              | 12 should be filed within in and Mental Hygiene. 7 is marked other than "fraumatic event, the Med  | To Be C          | 17. Father's Name (First, Middle, Las<br>Dymetro Holowcha  | k  |                      |   |   |                               | Cati                 | herin                    | First, Middle,<br>e Bort                  | nick                         | ·  |  |  |
|                     | 1 and 2 sh<br>Health and<br>em 27 is m<br>ther traum   |                  | 19a. Informant's Name/Relationship Harry A. Davis, 20a. Method of Disposition  |  | 20b. P               |   | Fairf   | ield                          |                      |                          | Crow                                      | nsvil                        | own, State, Zip<br>Le, MD<br>on - City or To | 21032  |  |
| Baltimore,          | nit. Pages<br>artment of<br>ortant: if it<br>Injury or o   |                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice   | ify)   | e c                  | emetery, crer<br>idowric                | natory or oth<br>Ige Mer                            | e <i>r place</i><br>n . I     | k.                   | 8/17/                    |   | Dorse                        | ey, Mar                                      |  |  |
| Ba                  | permi<br>Depa<br>impor<br>any Ir   |                  | 165 Fr   |  | 00770                | 3                                       | 313 Tal   | lbot                          | t Av                 | enue                     | Laure                                     | 1, Ma                        | ryland                                       | 20707<br>Approximate                             |  |
|                     | Physician<br>/Medical<br>Examiner  | ıer              | shock, or heart failure. List inly immediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immediate cause. Enter Underlying | a Chr  | ENIC<br>is a consequ |   | struc   | tı                            | ve                   | Pul                      | mong                                      | ry D                         | isase  | Interval Between<br>Onset and Death<br>5 Jeans   |  |
| ,0928               | cate be executed oblysician and the burial-transit   | dical Examiner   | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events<br>resulting in death) Last   | c  | is a consequ         | uence of):                              |   |                               |                      |                          |   |                              | :  |  |  |
| P.O. Box 6          | w requires that the death certific<br>been signed by the attending p<br>should be detached for use as:   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcom<br>1 ☐ Live birth<br>4 ☐ Pregnant<br>9 ☐ Unknown | 2 Fetal              | death 3                                 | ]Ectopic preg<br>]Other <i>(spec</i>                |                               |                      |                          |   | 23d.                         | Date of delive                               | ery<br>Day Year                                  |  |
|                     | equires that<br>en signed to<br>ould be det  | ed by P          | Part II. Other significant conditions  | contributing to death  | but not resu         | ılting in the ur                        | nderlying cau                                       | se give                       | n in Part I.         |                          | 23e. Did to                               |                              | =-   | ne cause of death?                               |  |
| or Vital Records,   | 2 8 2  | Completed by     |  |  |                      |   |   |                               |                      |                          | 24a. Was<br>autop<br>perfo<br>1 Yes       |                              | prior to cor<br>death?                       | psy findings available mpletion of cause of 2 No |  |
| or Vita             | Physician:<br>this certific<br>ral director,   | To Be            | 25. Was case referred to medical examiner?   | Hospital:  |                      | ER/Outpatien                            |   | Othe                          | r: 4 🗆 Nui           |                          | <i>Check only o</i><br>e 5 ☐ Resid        |                              | Other (Specif                                | Issisted   |  |
| Division o          | or Attending<br>fter death.<br>Director: After<br>in by the funer  | Certification:   | 27. Manner of D.llath  1   | 28e. Place of in   | ay Year)             | 28b. Time of<br>Injury<br>me, farm, str | М   |                               | at<br>?<br>ſes 2 □ N | 10                       | d. Describe h                             | Street and N                 |  | al Route Number,                                 |  |
|                     | To the Hospital or A within 24 hours after To the Funeral Direction Direction of the funeral Direction of the funeral Direction of the funeral filled in t | edical           | 29a. Certifier (Check only one)  1 Certifying P 2 Medical Exa  | hysiclan: To the bes<br>miner: On the basis<br>and manners           | of examinat          | wledge, death<br>tion and/or in         | n occurred at<br>vestigation, in                    | the tim                       | e, date an           | d place, ar              | nd due to the d<br>d at the time,         | cause(s) and<br>date and pla | d manner as s<br>ace, and due to             | tated.<br>o the cause(s)                         |  |
|                     | Vithi<br>Vithi<br>Com  | Me               | 29b. Signature and title of certifier  | Alik   | bran                 | M·D                                     |   | icense                        | number<br>43         | 32                       | 3 /                                       | 29d. Date si<br>1UGU         | gned (Month,<br>ST 14                        | 1. 2007  |  |
| /                   | <b>人</b> .   |                  | 30. Name and address of person who   | -Hicko   | ory                  | Rid                                     | Print) H  | R                             | 007<br>000           | A                        | Jui                                       | KH                           | ANM  | D 21044  |  |
|                     | Sta  | ite              | 31. Date filed (Month, Day, Year)  | 007 Hegis  | trar's Signa         | Los                                     | vie   |                               |                      |                          |   |                              |  | - / /  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11 **Physician** 2007 9:00 A. M Jeffrey Arthur Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours 1 ☑ M 2 ☐ F 3/4/1947 Director 212-50-6155 Balt.,Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Funeral Director Maryland Baltimore Cockeysville 10g. Citizen of What Country? United States of America 10f. Zip Code 10e. Street and Number 21030 18 Beehive Place Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Secondary (0-12) College (1-4or 5+) tal Hygiene. Accounting Accountant 12 18. Mother's Name (First, Middle, Maiden Surname) Thealth and Mental Hy tem 27 Is man 17. Father's Name (First, Middle, Last) Maryland Be Verna Elizabeth Quante Arthur Burnett Davis ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 Honeybee Court Apt. H Cockeysville, Maryland Pages 1 and 2 Verna Q. Davis/ mother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel- Bel Air Date 20c. Location - City or Town, State 20a. Method of Disposition August permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. August 2007 16, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Peaceful Alternatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 av, ser . P 1. En r the seas shock, or heart ailure. Approximate Interval Between Onset and Death sease, or compl. ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Immediate Cause (Final sshosis **Physician** ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner siclan and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physiclan for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö been signed by the should be detached 9□Unknown 9 Unknown or Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No 3 Probably 4 □Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an page 2 s autopsy certificate 25. Was case referred to medical examiner?

1 
Yes

2 
No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dether (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? Division Natural (Month, Day Year) or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) MLD 00057926 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Baltman ww 21204 656 Gardon State Registrar

DHMH 17 Rev 1/2001

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| Catherine Davis  |          | State<br>- For State<br>Legistrar   | _   | epartment o<br>Certificate o | f Health and Mer<br><i>f Death</i>                                 | ital Hygiene                     | Reg. No. 20                     | 07 2602   |
|--|----------|---|---|------------------------------|--|----------------------------------|---------------------------------|---|
| Physician  | 1        | 1. Decedent's Name (First, Middle,La  | est)                                      |                              | N . =  | 2. Date of<br>Month              | Death<br>Day Year               | 3. Time of Death  |
| Medical Examine  | 8        | CATHERIA<br>4a. Facility Name (if not institution, gi                                     | Le street and number                      | <del></del>                  | DAVIS 4b. City, Town, or Location                                  | Augus                            | t 12, 2007<br>4c. County of De  | 1155 hrs  |
|  |          | 519 East 28th Street  | ve street and number)                     |                              | Baltimore  | or Death                         | Ac. County of De                | IA  |
| Funeral  |          | 5. Social Security Number 6. 8  | Sex 7. Age (In                            | yrs. last birthday)          |  |                                  | of Birth (MM/DD/YYYY) 9.        | Birthplace (State or reign                                |
| Director   | 2        | 216-74-8216 1   | M 2XF                                     | 50 Yrs                       | Months Days Hour   | s Min. SEPI                      | .06,1956                        | Country) MARVLAND   |
| any.   | -        | Usual Residence of Decedent 10a. State 10b. County  | 10c                                       | . City, Town or Local        | tion   |                                  |                                 | 10d. Inside City Limits                                   |
|  | . l      | MARUI AND   | 1/A                                       |                              | BALTIM   | ORF C                            | ITU                             | 1 X Yes 2 No  |
| the Maryland<br>a or 28a-f show<br>tified at once.   | ין פרני  | 10e. Street and Number  |   |                              | 10f. Zip Code  | 1                                | 10g/Citizen of What C           | Country?  |
| death with the Maryland or items 23a or 28a-f sho must be notified at once.  | <u> </u> | 158 EXE   | TER HAL                                   | <u> </u>                     | 21   | 218                              | 1 113                           | 5A  |
| r death w  | i alie   | 11. Marital Status 1 X Never Married 2 Marrie   |   | . If Y                       | as Decedent of Hispanic Ori<br>Yes, specify Cuban, <b>M</b> exicar |                                  |                                 | merican Indian, Black,<br>c.                              |
| s after d  |          | 3 Widowed 4 Divorce   | 1 Yes 2                                   | 1                            | Yes 2 X No specify   | :                                | Specify:                        | BLACK   |
| 72 hours al Exami  |          | 15. Decedent's Education (Specify   |   |                              | nt's Usual Occupation (Givenost of working life. DO NOT            |                                  | 16b. Kind of Busine             | ess/Industry  |
| 136<br>Thin 72<br>Than than tedical  | ad .     | Elementary/Secondary (0-12)   | College (1-4 or 5+)                       | -//                          | NEMPLOY  | IED                              | 1                               | /a :  |
| 215-0036<br>be filed within 7<br>ntal Hygiene.<br>rked other than<br>ent, the Medica<br>Be Compile   | 34       | 17. Father's Name (First, Middle, Las   | t) George Washin                          | gton Davis                   | 18.Motive  | r's Name (First, Mid             | dle, Maiden Surname)            |   |
| 21215-00 21215-00 build be filed wit Mental Hygien marked other c event, the M   | ۱۵       | KICKIA  19a. Informant's Name/Relationship  |   | DAV13                        | g Address (Street and Nu   | ARV                              | Humber City or Tour S           | ALL<br>tota Zin Godo)                                     |
| AD 2 sho 2 sho 2 sho 27 is mati  | 1        | SHERRY HICK   |   | 110 6                        | USTING AV  | E CATO                           | NSVILLE M                       | D. 21228  |
| ore, N<br>ss 1 and<br>of Health<br>If item   |          | 20a. Method of Disposition  1 X Burial 2 Cremation 3                                      |   |                              | sition (Name of cemetery,<br>ther place)                           | Date                             | 20c. Location - City            | y or Town, State  |
| 트리의로토  |          | 4 Donation 5 Other Specific   |   | ARBUTUS                      | 5 CEMETERY   | 08-17-0                          | 17 BALTI                        | MORE, MA  |
| Ealtim<br>permit Pag<br>Department<br>Important:<br>injury or of   |          | 21. Si nature of Funeral Service Lice   | ensee Minar                               | 22.                          | Name and Address of Falli  | 4. BROK                          | ON TR. FU.                      | NERAL HOME  |
| Physician  | -        | 23a. Part I. Enter the disease, or com  |   | death. Do not enter t        | the mode of dying, such as   | cardiac or respirator            | y arrest, shock, or heart       | Approximate Interval                                      |
| /Medical<br>Examiner   |          | failure. List only one cause on a<br>Immediate Cause (Final disease                       | 1.0                                       | oin) and alc                 | ohol intoxication  | on                               |                                 | Between Onset and<br>Death                                |
|  | 1        | or condition resulting in death)  | Due to (or as a conseque                  | ence of):                    |  | 11.2                             |                                 |   |
| 100  | 5        | Sequentially list conditions, If any, leading to him colate cause. Enter Underlying Cause | Due to (or es e consecue                  | nce cry                      |  |                                  |                                 |   |
| ed nsit  | <u> </u> | (Disease or injury that initiated events resulting in death) Last                         | Due to (or as a conseque                  | ence of):                    |  |                                  |                                 |   |
| 60, ate be executed hysician and e burial - transit  |          |   | 1   | 20 07 00 6                   | 157 070 0  | /07 /07                          |                                 |   |
| ). Box 68760, the death certificate be execu by the attending physician and the for use as the burial - tra Physician/Medical  |          | X UNPENDED  | x AMENDED Item#2<br>#17.perFH.G8          | 70. 8/14/07                  | , perME,g870, 8/   | /2//0/ TT<br>                    |                                 |   |
| Sox 6876  Jeath certificat e attending phy for use as the  | 2        | F FEMALE:<br>3b. Was decedent pregnant in the<br>past 12 months?                          | 23c. If yes, outcome of                   | 2 F                          | etal death 3 Ectop   | ic pregnancy                     | 23d. Date of deli<br>Month      | very<br>Day Year  |
| Box 687  e death certifics the attending pled for use as th  | 5        | 1 Yes 2 ✓ No 9 Unknow   | 4 Pregnant at time 9 Unknown              | of death 5 O                 | ther (Specify)   |                                  | -                               |   |
| O. B<br>at the d<br>I by the<br>tached   |          | Part II. Other significant conditions   |   | t not resulting in the       | underlying cause given in P  | Part I. 23e. [                   | Did tobacco use contribute      | e to the cause of death?                                  |
| Division of Vital Records, P.O. tal or attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach by Partification: To Be Commission by Definion of the partification of the page 2 should be detach by Partification:   | 5        |   |   |                              |  | 1                                | Yes 2 V No 3 1                  | Probably 4 Unknown  |
| ords<br>aw requires<br>as been as been a   |          |   |   |                              | · · · · · · · · · · · · · · · · · · ·                              |                                  | autopsy prior                   | e autopsy findings available<br>to completion of cause of |
| tal Reccian: The Iscertificate heector, page 2   | 5        |   |   |                              |  |                                  | performed? deat<br>√es 2 No 1 ✓ |   |
| Vital Recysician: The his certificate director, page   |          | 25. Was case referred to medical examiner?  | Hospital: 1 Inpatient                     | 2 ER/Outpatien               | 26.Place of Death  | (Check only one)  Nursing Home 5 | Residence 6 🗸 O                 | ther: Scene   |
| of Vi  | • I •    | 1 ✓ Yes 2 No<br>27. Manner of Death   | 28a. Date of Injury<br>(Month, Day, Year) | 28b. Time of                 |  |                                  | ribe how injury occurred        | inter, Scene  |
| ion<br>Itendir<br>Ieath.<br>Iter: A  |          | 1 Natural 5 Pending 2 Accident Investiga  | End 9/12/200                              | 7 Fnd 11:                    | 40 am 1 Yes 2 7  | No unk                           |                                 |   |
| Division c<br>spital or Attending<br>nours after death.<br>meral Director: At<br>filled in by the fun  |          | 3 Suicide 6 X Could no determin   | t be 28e. Place of Injury                 |                              | et, factory, office building, e                                    | or Toy                           | vn. State)                      | Rural Route Number, City                                  |
| tospita<br>4 hours<br>funera   |          | 29a. Certifier (Continue Physic   | Topony Found                              |                              | rred at the time, date and pl                                      |                                  | 28th St. Balt                   |   |
| Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans Martical Certification: To Be Completed by Physician Martical Expension | 2015     | oncon only  | •   | -                            | ition, in my opinion, death o                                      |                                  |                                 |   |
| F × F ö  | Ĕ        | 29b. Signature and title of certifier   | -///1                                     |                              | 29c. License number  |                                  | 29d Date signed                 |   |
|  | 1        | AUIAI   |   | (1)                          | O.C.M.E.   |                                  | August 13, 20                   |   |
| 0 1  | 1        | 30. Name and address of person who<br>Susan Hogan MD. Ass                                 | completed cause of death                  |                              | nn Street, Baltimore,  | MD 21201                         |                                 |   |
| Stat   | е        | B1. Date filed (Month, Aug Ceal 4   | 200 732. Receivar's S                     |                              | andi   |                                  |                                 |   |
| Registra   | IT       | 7100 2 2  |   | 1                            |  | <u> </u>                         |                                 |   |

28a-f show "natural", or items 23a or 28a-f sh idical Examiner must be notified permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must to

3altimore, Maryland 21215-0036

Physician /Medical **Examiner** 

for use as the burial-tran Division or Vital Records, P.O. Box 68760, the attending physician To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 1:25 PM 2007 Marian Day 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Keswick Multi Care If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov 7, 1929 Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6 Sex Days Hours 1 ☐ M 2 😾 F 77 New Jersey 212-26-7822 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1√Yes 2□No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3310 Poole Street 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: white þ 3 ☐ Widowed 4 🎇 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Louis R. Criner Gladys Hess ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3320 Ridge Road Westminster, MD 21157 Bruce Smith/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. 

District for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, disease or condition resulting in death) Approximate Interval Between Onset and Death urkunun Due to (or as a consequence of): cardio un scular disease unkaowe Wilero acleritie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 W No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 3 Probably 4 Unknown Completed abeles Wellesers 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 atural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 013657 882 77D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARGREGOR 700 W 40th STREET, BALTIMRE, My 21211 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

|             |   |                | 1 - For<br>State<br>Registrar   | State o              | of Marylar                          | -                            | artment of H<br>rtificate of L                                    |                                     |  | giene<br>Reg. Nø. | 107                                    | 26022  |
|-------------|---|----------------|---|----------------------|-------------------------------------|------------------------------|---|-------------------------------------|--|-------------------|--|--|
|             | 24  |                | 1. Decedent's Name (First, Middle   | , Last)              |                                     |                              |   |                                     | 2. Date of Dea                           | ath               |  | 3. Time of Death                             |
|             | Physici<br>/Medio   |                | Doro  | thy M. Er            | nest                                |                              |   |                                     | Month<br>August                          | Day 1.0           | Year 2007                              | 2:00 AM                                      |
|             | Examir  |                | 4a. Facility Name (If not institution   | , give street and nu | ımber)                              |                              | 4b. City, Town, or  | Location of De                      |  |                   | unty of Death                          |  |
|             |   |                | St. Elizabeth   | Nursing              | and Reh                             | ab                           | Ba1   | timore                              |  |                   |  |  |
|             | Funeral   |                | 5. Social Security Number   | 6. Sex               | 7. Age (In yrs.                     |                              | If Under 1 Year<br>Months Days                                    | If Under 24 H<br>Hours Mi           |  | h<br>V Vear)      | 9. Birth                               | place (State or Foreign                      |
| 4           | Director  |                | 214-24-7919   | 1 □ M 2 🖾 F          | 85                                  | Yrs.                         | World S Days  | Hours Wil                           | March                                    |                   | 22 Mar                                 | vland  |
|             | pu ,  |                | Usual Residence of Decedent   |                      | 140.00                              |                              |   |                                     |  |                   |  |  |
|             | aryla<br>shov   | _              | 10a. State 10b. County  |                      | 10c. G                              | ty, Town or Lo               | cation  |                                     |  |                   | ľ                                      | 10d. Inside City Limits                      |
|             | 8a-f  | Sch            | Maryland  |                      |                                     | Balt                         | imore   |                                     |  |                   |  | 1 X Yes 2 No                                 |
|             | or 2  | Director       | 10e. Street and Number  | 11                   |                                     |                              | 10f. Zip Code   |                                     |  | 10g. Citizen      | of What Cou                            | ntry?  |
|             | death with the Maryland<br>rms 23a or 28a-f show<br>r must be notifled at   | 2              | 623 South   |                      |                                     |                              | 2122  |                                     |  | USA               |  |  |
|             | tems  | Funeral        | 11. Marital Status  | Armed F              |                                     | l.S. 13.                     | Was Decedent of His<br>If Yes, specify Cuba                       | spanic Origin?<br>n, Mexican, Pu    | (Specify Yes or No-<br>erto Rican, etc.) | . 14.             | Race - Americ<br>Black, White,         |  |
| 36          | or i  | by F           | 1 ☐ Never Married 2 ☐ Marr<br>3 ☑ Widowed 4 ☐ Divorced  | If Yes, G            | ive                                 |                              | 1 ☐ Yes 2 ☑ No  | Specify:                            |  | Sp                | ecity: Wh                              | nite   |
| 21215-0036  | n 72 hours after death with the Marylan<br>"natural", or items 23a or 28a-f show<br>edical Examiner must be notified at   | 호              |   | Year or E            | Jales:                              | 160 Door                     | last's Henry Ossure   | 41                                  |  | 101 101 1         |  |  |
| 15          | "na<br>edle   | Completed      | 15. Deceden<br>(Specify only higher   | t grade completed)   |                                     | (Give                        | dent's Usual Occupa<br>kind of work done d<br>DO NOT use retired) | uning most of w                     | orking                                   |                   | of Business/In $\cdot$ Filb $\epsilon$ | 1  |
| 12          | with<br>ene.<br>thar<br>he M  | Ĕ              | Elementary/Secondary (0-12)   | College (            | 1-4or 5+)                           |                              | cker  |                                     |  |                   | garine                                 | ert s  |
| d 2         | filed<br>Hygi<br>ent, t   |                | 17. Father's Name (First, Middle,   | Last)                |                                     | I Fa                         | ICKEI   | 18. Mother's N                      | ame (First, Middle,                      |                   |  |  |
| an          | ld be<br>ental<br>ked c   | To Be          | William Del   | ah an tu             |                                     |                              |   |                                     |  |                   | ,                                      |  |
| Maryland    | shoul<br>mari   | F              | 19a. Informant's Name/Relations   |                      |                                     | 19b. Mailir                  | ng Address (Street a  | Ua.1<br>and Number or               | therine C                                | L1TTO1            | rd<br>wn State Zir                     | Code)  |
|             | ulth all  |                | Marie E. Peigh  | tel - Dai            | ohter                               |                              | South Wic   |                                     |  |                   |  |  |
| ē,          | tem tem   |                | 20a. Method of Disposition  | ter but              |                                     |                              | sition (Name of natory or other place                             |                                     | Date Date                                |                   | on - City or To                        |  |
| Baltimore,  | permit. Pages 1 and 2 should be filed within 72 hc<br>Department of Health and Mental Hygiene.<br>Important: If item 27 Is marked other than "natu<br>any injury or other traumatic event, the Medital<br>once. |                | 1 XBurial 2 □Cremation<br>4 □Donation 5 □ Other (S  |                      | State                               |                              |   | 4                                   | 1/ 2007 -                                |                   | -                                      |  |
| Ė           | artme<br>ortan<br>Injur   |                | 21. Signature of Funeral Service  |                      | 2 / Da                              | it. Na                       | t1. Cemet   | ery 8-                              | 14-200/   <br> terling=4                 | Saltim            | ore, M                                 | aryland                                      |
| Ba          | permi<br>Depa<br>Impo<br>any ir   |                | MAG   |                      |                                     | ļ                            | Name and Address<br>uneral Hot<br>630 Edmon                       | me of C                             | atonsvill                                | le, Iņ            | ic.                                    | D-WILZKE                                     |
|             |   |                | 23a. Part. Enter the disease, or  | o molications that   | caused the deat                     | h Do not ent                 | er the mode of dvino  | uson Av                             | enue; cat                                | onsv1             | IIe, M                                 | D 21228 Approximate                          |
|             |   |                | shock, or heart failure. List<br>Immediate Cause (Final   | only one cause on (  | eech line.                          |                              | -   |                                     |  |                   | 1                                      | Interval Between<br>Onset and Death          |
|             | Physician<br>/Medical   |                | disease or condition resulting in death)  | a.C'e                | Rebr                                | DUAS                         | CULAR   | Acc                                 | iden T                                   |                   |  | 5 days.                                      |
| -           | Examiner  |                |   | Due to               | (or as a consec                     | juence of):                  | CULAR   | T                                   |  | 1                 |  |  |
|             |   | -              | Sequentially list conditions, if any leading to immediate   | b. Due to            | (or as a conseq                     | uence of):                   | CUAR  | INS                                 | OFFICE                                   | ewy               | /                                      | YEAR   |
| P           | nsit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury |                      | (                                   | ,                            |   |                                     |  | /                 |  | /  |
| 68760,      | ficate be executed<br>physician and<br>is the burial-transit  | ха             | that initiated events<br>resulting in death) Last   | c                    | (or as a conseq                     | uence of):                   |   |                                     | <u> </u>                                 |                   |  |  |
| 290         | siclar<br>buri  | <u>e</u>       |   |                      |                                     |                              |   |                                     |  |                   |  |  |
| 687         |   | edical         |   | d                    |                                     |                              |   |                                     |  |                   |  |  |
| Box (       | leath certif<br>attending<br>for use as   | Ě              | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, ou      | tcome pf pregna                     | ancy                         |   |                                     |  | 224               | . Date of delive                       | on   |
| ă           | atter<br>for u  | Physician/M    | in the past 12 months?  | 1 ☐ Live             | birth 2 ☐ Feta<br>nant at time of c | al death 3□                  | Ectopic pregnancy Other (specify)                                 |                                     |  | 230.              | Month                                  | Day Year                                     |
| Ö           | the d<br>y the<br>ched  | ıysi           | 1 □ Yes 2 ☑ No<br>9 □ Unknown   | 9□Unkn               |                                     |                              | ( (aposity)   |                                     |  |                   |  |  |
| σ,          | law requires that the death certi<br>as been signed by the attending<br>2 should be detached for use a  |                | Part II. Other significant condition  | ns contributing to d | eath but not res                    | ulting in the ur             | nderlying cause give  | n in Part I.                        | 23e. Did to                              | bacco use         | contribute to t                        | he cause of death?                           |
| Records,    | uires<br>sign<br>Id be  | d by           | Severe Col  | 20NARY               | . HOA                               | RT IT                        | rease.  | r de                                | 1 U Y                                    | es 2              | lo 3 ☐ Prot                            | pably 4 □Unknown                             |
| Ö           | w requir<br>been si<br>should b   | ete            | 11.   | 11-11                |                                     | 1.                           | emen  | - 1                                 | 040 14/00                                |                   | 41- 141                                |  |
| Re          | The lav<br>ate has<br>bage 2 s  | Completed      | MOUNTED   | 4/246                | MER                                 |                              | EMER  | UH                                  | 24a. Was a<br>autop<br>perfor            | sv                | prior to co<br>death?                  | opsy findings available mpletion of cause of |
| ā           |   | _              | MRONIC REA  | IN FAI               | 14RC                                |                              |   |                                     | 1□ Yes                                   | 2 PNo             | 1 ☐ Yes                                | 20 No  |
| Vital       | Physiclan:<br>this certific<br>ral director,  | Be             | 25. Was case referred to medical examiner?  | Hospital:            |                                     |                              | Othe  | r. /                                | eath (Check only or                      |                   |  |  |
| ō           | Phys<br>r this<br>ral dir   | -T             | 1 Yes 2 No  | 28a. Date            | Inpatient 2  of Injury              | ER/Outpatien<br>28b. Time of | 1 3 LI DOA  | 4 Nursing                           | Home 5 Resid                             |                   |  | (y)  |
|             | ding Ph   | io             | 1 Matural 5 ☐ Pending   | (Mon                 | th, Day Year)                       | Injury                       | 28c. Injury<br>Work'<br>M 1 ☐ Y                                   | at<br>?<br>′es 2∐No                 | 28d. Describe h                          | ow injury oc      | currea                                 |  |
| Division    | or Attending<br>after death.<br>Director: After<br>in by the fune   | Certification: | 3 ☐ Suicide 6 ☐ Could n   | ot be                | of injuny - At he                   | ome farm str                 | eet, factory, office  | es 2 100                            | 20f Logotion (6                          | tenne and Al      | umber on Dun                           | al Banda Alumbas                             |
| <u>&gt;</u> | or A<br>after<br>Direction by   | Ħ              | 4 ☐ Homicide determi  |                      | ing, etc. (Specit                   |                              | set, factory, office  |                                     | City or Tow                              |                   | umber or Hura                          | al Route Number,                             |
| _           | purs on seral filled  |                | 29a. Certifier 1 Certifyin  | Physician: To the    | hest of my kno                      | wledge death                 | occurred at the tim   | a data and pla                      | no and due to the                        | 201100(0) 021     | 1                                      | A-4-d  |
|             | 24 hos<br>24 hos<br>Fun<br>etely  | Medical        | (Check only 2 Medical I   | xaminer: On the b    | asis of examina<br>ner stated.      | ition and/or in              | estigation, in my op  | e, date and pla<br>pinion, death oc | curred at the time,                      | date and pla      | ace, and due to                        | o the cause(s)                               |
|             | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu  | Me             | 29b. Signature and title of certifier   | and man              | orated.                             | ~                            | 29c. License  | number                              |  | 29d. Date si      | gned (Month,                           | Day, Year)                                   |
|             | ⊢s⊢ŏ  |                | Willow .  | 10-                  | TENDING                             | Mo                           |   |                                     |  | 1                 | 20-11                                  | 7000   |
|             |   |                | 20 Name and address to  |                      |                                     |                              | ICYAN [   | 1162                                | 00 /                                     | 1090              | 3/11/                                  | 2001   |
|             | 3   |                | 30. Name and address & person   |                      | -                                   | 720 Type,                    | rint)   | المصح                               | Choice                                   | 0/-               | Cn-                                    | 21228  |
|             | Sta   | to.            | 31. Date filed (Month, Day, Year)   |                      | Registrar's Signa                   |                              | - 19A   | NEW                                 | CHOIC 6                                  | = hA              | HTO                                    | wsume,                                       |
|             | Sta   |                | NIIG 1 4  | 007                  | g.c. a. c. syle                     | dona                         | 81.3  |                                     |  |                   |  | •  |

07-06159 Jane Fairman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month August 10, 2007 1412 hrs Medical Examiner -Jane Fairman Jane Sherri Fairman 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Johns Hopkins Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** Days 11/11/1943 Country) WI Months Hours Min. 395-42-0461 63 Director 2 **X**F м Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 X Yes 2 No Pikesville MD Baltimore 23a or 28a-f show notified at once, Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 3306 21208 Terrapin Road 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status lant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces 1 Never Married 2 X Married 2 X No White Yes Yes 2 X No specify: Specify Divorced If Yes, Give Year þ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) within 72 Own Home Homemaker timore, MD 21215-0036 12 1 Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. 18. Mother's Name (First, Middle, Maiden Surname)
Fannie Burman 17. Father's Name (First, Middle, Last)
Milton Aaron 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print ) 1311 San Mateo Drive, Allen, TX 75013 Tom Fairman / Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition crematory or other place)
Beth Hamedrosh Burial 2 Cremation 3 X Removal from State 8/14/2007 Milwaukee, WI Other Specify Donation 5 Cemeter 22. Name and Address of Facility 21. Signature of Funeral Service Licer 0d mJ Charles L. Stevens Funeral Home Inc. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as carriac of respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Complications of cervical spinal stemosis surp Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed and Physician/Medical X AMENDED NE, g871, 9/26/07 TT / #23a.27.28a-f, perME, G872, X UNPENDED ending physician use as the burial 10/2/07 TI Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Month Year 3 Ectopic pregnancy Day Live birth Fetal death Pregnant at time of death Other (Specify) Yes 2 No 9 ✔ Unknown 9 Unknown the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ≥ 1 Yes 2 No 3 Probably 4 ✔ Unknown Records, P. Completed 24b. Were autopsy findings available 24a. Was an been prior to completion of cause of autopsy has death? performed? page 2 s 2 No ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) Hose hal or Attending Physician: 25. Was case referred to medica Division of Vital Be examiner? Hospital: 1 Inpatient 2 Other DOA Nursing Home 5 Residence 6 Other: ER/Outpatient 3 this 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey, Yeer) 28b. Time of Injury 27. Manner of Death After 1 Yes 2 X No Natural Pending Director: 8/8/2007 unk. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be 3 Suicide 600 N. Wolfe St. Baltimore MD determined hospital Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 12, 2007 O.C.M.E an zind alru 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant, Medical Examiner Patricia Aronica-Pollak MD. 31. Date filed (Mont oistrar's Signatur State 2007 Registra

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registra Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician ELMFR** Marshal L August 12 10:30 PM FEETE 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | October 4, 1911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral **XX** M 2□ F 95 212-05-0750 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore Parkville 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 8810 Walther Blvd 21234 IISA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2XXNo White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman/Owner Casket Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event sones. James Marshall Feete Edna Mary Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Feete Ayres 1027 Coldspring Road Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XXBurial 2 Cremation 3 Removal from State Oaklawn Cemetery 8/16/07 □ Donation 5 □ Other (Specify) Baltimore, Maryland ignature of Funeral Service Ligensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc ELA) 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 8 days burial-transit

Physician /Medical Examiner

physician s the burial

attending pl

signed by the at d be detached for

: After this certifical funeral director,

ector: by the

within 24 hours att To the Funeral Di completely tilled in

in by atter Dire

death.

with the Maryland

 $\mathcal{L}_{\mathcal{C}}\mathcal{C}$   $\mathcal{L}_{\mathcal{C}}$   $\mathcal{L}_{\mathcal{C}}$  Itimore, Maryland 21215-0036

Examiner Completed by Physician/Medical Be Medical Certification: To

o the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

| G-0 1 0 1 0 0 1 1 1   | per control or control   |          |
|---|--|----------|
| 23a. Part1. Enter the disease, or shock, or heart failure. List of  |  | 1        |
| Immediate Cause (Final disease or condition resulting in death)   | Due to (or as a consequence of):   | 8        |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b  |          |
| resulting in death) Last  | Due to (or as a consequence of):   |          |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  | 23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  23d. Date of or Month | delivery |

in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. prostate

23e. Did tobacco use contribute to the cause of death? 2 ENo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autoosy

performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

D52197

R. MOTAGE M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N. WARLES ST. BALTIMORE, MD 21204

8-13-2007

Day

2 No

Year

State Registrar 31. Date filed (Month, Day, Year)

REKH A MOTAGI



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year BRANDEN AUGUST 2:15 PM 7007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | March 3, 1987 JATI 92017 Baltimore NORTHWEST 5. Social Security Number 6. Sev 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Yrs. 219-27-4755 20 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at MD 1 ☐ Yes 2 ☑ No Director Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 1035 Middle River Road 21220 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc within 72 hours after 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify: 3 3 Widowed 4 Divorced Completed the Medicai 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) unemployed Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I Janet Fadelv Paul Leber, Jr. Pages 1 and 2 should or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Irriportant: If item 27 is any Injury or other traugence. Miss Angela Adkins/fiance 1035 Middle River Rd, Middle River, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/10/2007 Glen Haven Cemetery Glen Burnie 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Paneral Service Licensee 22. Name and Address of Facility
1 Second Ave SW Glen Burnie MD 21061 Part . Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BRAIN ABSCESS **Physician** /Medical Due to (or as a consequence of) Examiner ENDOCARDITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine DRUG INTRAVENOUS attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has certificate 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Dea 28b. Time of 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54352 AUGUST 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITCEA TODOK RANDALLSTOWN MARYLAND 21133 DO RETHWEST HOSPITAL SHOL OLD COURT ROAD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 14 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Year H. Grant Parmela 5:40PM 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CONTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits 28a-f show iral", or Items 23a or 28a-f shov Examiner must be notified at 1XYes 2 No Funeral Director 10e. Street and Number 10g. Offizen of What Country? 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", Health and Mental Hygiene. tem 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 THGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l GRANDMOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 200 Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 7 days /Medical (or as a consequence of): Due ti Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, bissues or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 mon Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by THABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has treetor, page 2 s autopsy performed' 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) F005/01/80 Vevacue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar . SOUTH GREENE

31. Date filed (Month, Day, Year)

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DANICA MOVACE C

BALTIMORE

32. Registrar's Signature

|  |                | 1 - For State Registrar  | State of               | Marylar                |                                  |             | nt of H<br>te of L            |                  |                            | lental Hy                       | giene<br>Reg. No. | 2007                          | 1 2                       | 6027                   |
|--|----------------|--|------------------------|------------------------|----------------------------------|-------------|-------------------------------|------------------|----------------------------|---------------------------------|-------------------|-------------------------------|---------------------------|------------------------|
| - 10   |                | Decedent's Name (First, Middle,  | Last)                  |                        |                                  |             |                               |                  |                            | 2. Date of De                   | ath               |                               |                           | ime of Death           |
| Physici<br>/Medi   |                | Leno Anthony   | briorgio               |                        |                                  |             |                               |                  |                            | Aurust                          | Day 10:           | m 200                         | 16                        | 50 PM                  |
| Examir   |                | 4a. Facility Name (If not institution,                                 |                        | ber)                   |                                  | 4b. Cit     | y, Town, or                   | Location         | of Death                   | 110                             |                   | County of Dea                 | ath                       |                        |
|  |                | Battimure  | VA                     |                        |                                  |             | Bal                           | timor            | Q.                         |                                 |                   | ,                             |                           |                        |
| Funeral  |                | 5. Social Security Number 6  |                        | . Age (In yrs.         |                                  | If Und      | er 1 Year<br>Days             | If Under         | r 24 Hrs.<br>Min.          | 8. Date of Bird<br>(Month, Da   | th<br>v. Year)    | 9. Bi                         | inthplace (               | State or Foreign       |
| Director   | ١.             | 217-22-2896  | 1(XM 2□F               | 8.                     | 2 Yrs.                           |             |                               |                  |                            | Nov. 1,                         |                   | ,                             | ryĺai                     | nd                     |
| pur *  | }              | Usual Residence of Decedent  10a. State 10b. County                    |                        | 10c Ci                 | ty. Town or L                    | ocation     |                               |                  |                            |                                 |                   |                               | 10d In                    | side City Limits       |
| sho  | ō              | West   |                        | 100.0                  |                                  |             |                               |                  |                            |                                 |                   |                               |                           | Yes 2⊠No               |
| 28a-1  | Director       | Virginia Berke.  10e. Street and Number                                | Ley                    |                        | Hedge                            |             | Le<br>Lip Code                |                  |                            |                                 | 10g Citiz         | en of What C                  |                           |                        |
| ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Itam 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Madical Examinat must be notified at | ā              |  |                        | -1 Dos                 | . 1                              | 101. 2      |                               | 1.07             |                            |                                 |                   |                               | zouritry :                |                        |
| na 23  | Funeral        | 2568 Provid  | 12. Was Deced          |                        |                                  | Was Dec     |                               | 427              | rigin? (Spe                | ecify Yes or No                 | - US              | 4. Race - Am                  | nerican Ind               | ian.                   |
|  | Ξ              | 1 ☐ Never Married 2 🔀 Marrie   | Armed Ford             | es?                    |                                  | If Yes, sp  | ecify Cuba                    | n, Mexica        | in, Puerto                 | ecify Yes or No<br>Rican, etc.) |                   | Black, Wh                     | ite, etc.                 |                        |
| O. Take  | þ              | 3 ☐ Widowed 4 ☐ Divorced   | If Yes Give            | es: 1943               | -45                              | 1 🗌 Yes     | 2 🔀 No                        | Specify          | <b>:</b>                   |                                 |                   | Specify: W                    | Thite                     |                        |
| stur   | Completed      | 15. Decedent's   |                        |                        | 16a. Dece                        | dent's Us   | ual Occupa                    | ation            |                            |                                 | 16b. Kin          | d of Busines                  | s/Industry                |                        |
| - W  | pie            | (Specify only highest<br>Elementary/Secondary (0-12)                   | College (1-            | 4or 5+)                | life.                            | DO NOT      | rork done d<br>use retired    | iuring mo:<br>') | st of worki                | ng                              |                   |                               |                           |                        |
| giene<br>er th   | E O            | 12   | Comage (1              | 401 517                | Main                             | tena        | nce                           |                  |                            |                                 | Wa                | ter Tr                        | eatm                      | ent                    |
| oth A  | Be             | 17. Father's Name (First, Middle, La                                   | ast)                   |                        |                                  |             |                               | 18. Moth         | er's Name                  | (First, Middle,                 | Maiden S          | Sumame)                       |                           |                        |
| Menta<br>rked<br>tice  | 2              | Antonio Aug  | ustus Gio              | rgio                   |                                  |             |                               | Jos              | sephi                      | ne Ross                         | i                 |                               |                           |                        |
| and and  | 1.8            | 19a. Informant's Name/Relationshi                                      | p (Type, Print)        |                        | 19b. Mail                        | ing Addre   | ss (Street a                  | and Numb         | er or Rura                 | al Route Numbe                  | er, City or       | Town, State,                  | Zip Code                  | )                      |
| Department of Health a Important: if itam 27 is any injury or other tra  |                | Betty J. Giorg   | io - Wife              |                        | 256                              | 8 Pr        | ovide                         | nce (            | Churc                      | h Road;                         | Hed               | gesvil                        | le, I                     | JV 2542                |
| r oth  |                | 20a. Method of Disposition   |                        |                        | Place of Disponentery, cre       | osition (N  | ame of<br>other place         | e)               | 0                          | Date                            | 20c. Loc          | ation - City o                | or Town, S                | tate                   |
| int: H   |                | 1 ☑ Burial 2 ☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spe              |                        |                        | sedale                           | Cem         | etery                         |                  | 8-15-                      | -2007                           | Mart              | insbur                        | g, W                      | V                      |
| y inju   |                | 21. Signature of Euneral Service Li                                    | censee                 | 2/                     | 2                                | 2. Name     | and Addres                    | s of Facil       | iy Ste                     | rling-A                         | shto              | n-Schw                        | ab-W                      | itzke                  |
| any<br>any   |                | Close  | Sel 1                  |                        | F                                | uner<br>630 | al Hon                        | me oi<br>dson    | t Cat<br>Aven              | onsvill<br>ue; Cat              | e, I              | nc.<br>Ille.                  | MD 2                      | 1228                   |
| TIEN   |                | 23a. Part1. Enter the disease, or c                                    | omplications that ca   | used the deat          |                                  |             |                               |                  |                            |                                 |                   |                               | Appr                      | oximate<br>val Between |
| sician   |                | shock, or heart failure. List or<br>Immediate Cause (Final             | ny one cause on ea     | cri iine.              |                                  |             |                               |                  |                            |                                 |                   |                               | Onse                      | t and Death            |
| edical   |                | disease or condition<br>resulting in death)                            | a. Due to (o           | r as a consec          | mence of).                       |             |                               |                  |                            |                                 |                   |                               |                           |                        |
| miner  |                |  | _                      | cteremis               |                                  |             |                               |                  |                            |                                 |                   |                               | 3.                        | -5 Mys                 |
|  | ě              | Sequentially list conditions, if any, leading to immediate             | D                      | r as a consec          |                                  |             |                               |                  |                            |                                 |                   |                               |                           |                        |
| physician and<br>s the burial-transit  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events |                        |                        |                                  |             |                               |                  |                            |                                 |                   |                               |                           |                        |
| rial-tr  | Exa            | resulting in death) Last   | Due to (o              | r as a consec          | juence of):                      |             |                               |                  |                            |                                 |                   |                               |                           |                        |
| ng e   | dical          |  | d                      |                        |                                  |             |                               |                  |                            |                                 |                   |                               |                           |                        |
| ng pri   | ed             |  |                        |                        |                                  |             | -50                           |                  |                            | 20                              | - 1               |                               | 1                         |                        |
| euaic<br>euaic   | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant                               | 23c. If yes, outco     | ome of pregnath 2 Feta |                                  | Tectonic    | pregnancy                     |                  |                            |                                 | 23                | 3d. Date of de                | elivery                   |                        |
| been signed by the attending p<br>should be detached for use as  | icia           | in the past 12 months?<br>1 □ Yes 2 □ No                               | 4☐Pregna               | nt at time of o        |                                  | Other (     |                               |                  |                            |                                 |                   | Month                         | Day                       | Year                   |
| lache  | hys            | 9 Unknown  | 9∐ Unknov              | vn                     |                                  |             |                               |                  |                            |                                 |                   |                               |                           |                        |
| oe de  | by P           | Part II. Other significant condition                                   |                        | ith but not res        | sulting in the u                 | ındərlying  | cause give                    | n in Part        | ł.                         | 23e. Did t                      | obacco us         | e contribute                  | to the cau                | se of death?           |
| old blu  | pa             | Atrial Fibrilla  | tion                   |                        |                                  |             |                               |                  |                            | 10                              | res 2 🗴           | No 3□F                        | Probably                  | 4 Unknown              |
| s bee  | Completed      |  |                        |                        |                                  |             |                               |                  |                            | 24a. Was                        |                   | 24b. Were a                   | autopsy fin               | dings available        |
| age (  | E              |  |                        |                        |                                  |             |                               |                  |                            | autop                           | rmed?             | prior to<br>death?<br>1 🗀 Ye  | 40                        | on of cause of         |
| tifice<br>for. p   | 0              | 25. Was case referred to medical                                       |                        |                        |                                  |             |                               | 26 Plac          | e of Death                 | 1 ☐ Yes                         | 2 No              | 1 10 16                       | s 2/1                     | 10                     |
| s cer<br>direct  | To B           | examiner?<br>1 ☐ Yes 2 🗶 No  | Hospital:              | patient 2              | ER/Outpatie                      | nt 3D F     | Othe                          | 200              |                            | me 5 ☐ Resid                    |                   | Other (Sn                     | aciful                    |                        |
| eral (   |                | 27. Manner of Death  | 28a. Date of           | Injury                 | 28b. Time o                      |             | 28c. Injury                   | at               |                            | 28d. Describe I                 |                   |                               | 00.177                    |                        |
| r: Aft   | 왕              | 1 Natural 5 Pending<br>2 Accident investiga                            |                        | Day Year)              | Injury                           | М           | Work                          | <br Yes 2 🗀      | ]No                        |                                 |                   |                               |                           |                        |
| by th  | ill Ci         | 3 Suicide 6 Could no   | ed 286. Place o        | f Injury - At h        | ome, farm, st                    | reet, facto | ory, office                   |                  | - :                        | 28f. Location (                 |                   | Number or F                   | Rural Rout                | e Number,              |
| d in l   | Certification; | 4  Homicide  | building               | g, etc. (Speci         | y)                               |             |                               |                  |                            | City or Tov                     | vn, State)        |                               |                           |                        |
| To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  | edicai C       | 29a. Certifier 1 Certifying (Check only one) 2 Medical Exponen         | Physician: To the base | is of examina          | owledge, deat<br>ation and/or in | th occurre  | d at the time<br>on, in my op | ne, date a       | nd place, a<br>ath occurre | and due to the ed at the time,  | cause(s) a        | and manner a<br>place, and du | as stated.<br>ue to the c | ause(s)                |
| mple   | Med            | 29b. Signature and title of certifier                                  | and manne              | or Stated.             |                                  | 2           | 9c. License                   | numhar           |                            |                                 | 29d Data          | signed (Mor                   | nth. Day V                | (ear)                  |
| ¥ 8  |                | 255. Organization and title of certifier                               | 9                      |                        |                                  | -           |                               |                  |                            |                                 |                   |                               |                           | ,                      |
|  |                | In   | 414                    |                        |                                  |             | 44417                         | 6435             | 6180                       | 268                             | AL                | izust 1                       | 10 th                     | 2007                   |
| 6  |                | 30. Name and address of person w                                       | no mpleted cause       | of death (Iter         | n 23a) (Type,                    | Print)      |                               |                  |                            | 268<br>a Ba                     |                   |                               |                           |                        |
| _  |                | Vikram Gill  | M.D. 110               | 5. Pac                 | 2 54,                            | 6 12        | Floor,                        | Suite            | 200                        | a, Ba                           | Thima             | a, MP                         | 212                       | 01                     |
| Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)                                      | 007 32. He             | gistrar's Signa        | RUFB                             |             |                               |                  |                            |                                 |                   |                               |                           |                        |
|  |                | 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1                                 | 1111/                  | 100                    | 1/20                             | ANTA B      |                               |                  |                            |                                 |                   |                               |                           |                        |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death GARRISON JR ALFRED 17:32 M AUGUST 2007 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) Age (In yrs. last birthday. Hours 1,₽M 2□ F Days -10 00 Usual Residence of Decedent 10b. County 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number Was Decedent Ever in U.S. Armed Forces? Race - Ameri Black, White, 11. Marital Status 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Yes 2 No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during n life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) ndary (0-12) Mather's Name (First, Middle, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenside the lisease, or complications that caused the death. r heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pneumonia month resulting in death) Due to (or as a consequence of): Immunodeficiency Virus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Human 10 years Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 TYes 2 No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be a

Pages 1 and 2 si ould be filed within 72 hours after

if of Health and If item 27 is ria

ö Department of Important: If any Injury or

altimore, Maryland 21215-0036

Director

Funeral

Completed by

Be 2

Examiner burial-trai Physician/Medical the attending pl for use as t ate has been signed page 2 should be det Be Completed by funeral director. Certification: To

The law requires that the death certificate be executed

Records, P.O. Box 68760

Division or Vital

To the Hospital or Attending Physiclan:

this

After

s after death.

If Director: A

d in by the fu

within 24 hours a To the Funeral L

filled in by

completely

Medical

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1X Natural

2 Accident

3 Suicide

4 ☐ Homicide

5 ☐ Pending investigation 6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of Injury

Other: 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

MEDICAL DOCTUR

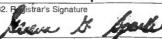
29c. License number **RES-000**  29d. Date signed (Month, Day, Year) AUGUST, 11, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TUAN M. TRAN, JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BUTTIMORE, MARYLAND 21287 31. Date filed (Month, Day, Year)

State Registrar

AUG 1 4



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 9: 20 am. **Physician** Muanst 0 200 <u>Helen Ann Godsey</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. agnes Health Itimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🕱 F 214-44-6173 69 Director 12/28/1937 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 X Yes 2 ☐ No Director MD n/a Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 320 Millington Ave United States
14. Race - American Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lawrence B. Stout Poly Melissa Dayton ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra once. 320 Millington Ave. Baltimore, Maryland 21223
Disposition (Name of Date 20c. Location - City or Town, State George Godsey / husband 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crestlawn Memorial 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 08/13/2007 | Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Furnaral Service Licenses 1328 Sulphur Spring Rd. Arbutus, Maryland 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hearst Atheroscleratic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to firm solute cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-tran Due to (or as a consequence of): (100 LSe/s) He/e n Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atter Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HyperTension. 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 **\**\ 1 ☐ Yes 1∐ Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Vo Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred T Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: A
d in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funeral C completely filled i Type Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of co MYSICIAN 2007 D0024228 30. Name and address of peron who completed cause of death (Item 23a) (Type, Print) 10

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

AUG 14

2007

Agnes

12 MD

32. Registrar's Signature

State Registrar

Baltimore, Maryland 21215-0036

P.O. Box 68760

Vital Records,

Division or

JOSEPHINE GANGI

AUG 1 DHMH 17 Rev 1/2001

32. Registrar's Signature

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

4

DR. TARIO MAHMOOD

31. Date filed (Month, Day, Year)

TIMONIUM, MD 21093

|                                |   |                | 1 - For<br>State<br>Registrar  | State of Marylan   |  | artment of H                                  |   | , ,                                      | ene<br>g. No2007                             | 26031  |
|--------------------------------|---|----------------|--|--|--|---|---|--|--|--|
| 0                              | Physici   | an             | 1. Decedent's Name (First, Middle, Last)   |  |  |   |   | Date of Death     Month                  | Day Year                                     | 3. Time of Death                                   |
|                                | /Media  |                | Leo E. Gordy Sr  |  |  | 41. O'll. T                                   |   | 149451                                   | 5 2007                                       |  |
| >                              | Examin  | er             | 4a. Facility Name (If not institution, give s  PININSULA REGISHED                  |  | land   |   | Location of Death                           | ,  | 4c. County of Dea                            |  |
|                                | Funeral   |                | 5. Social Security Number 6. Sex   | 7. Age (In yrs.  | last birthday)   | If Under 1 Year                               | If Under 24 Hrs.                            | 8. Date of Birth                         | 9. Bir                                       | thplace (State or Foreign                          |
|                                | Director  |                | 213 <b>-</b> 14 <b>-</b> 6374  | M 2□F 82   | Yrs.   | Months Days                                   | Hours Min.                                  | Nov 27,                                  | 1924 Mar                                     | ountry)<br>yland                                   |
|                                | pui »   |                | Usual Residence of Decedent  10a. State 10b. County                                | 10c Cit  | y, Town or Lo  | cation  |   |  |  | 10d. Inside City Limits                            |
|                                | Maryle<br>f shored at   | ō              | MD Wicomico  |  | Delma  |   |   |  |  | 1 □Yes 2√ No                                       |
|                                | the N<br>28a-<br>notifi   | Director       | 10e. Street and Number   |  | Derma  | 10f. Zip Code                                 |   | 10                                       | g. Citizen of What C                         |  |
|                                | h with<br>23a or<br>st be   |                | 30537 E. Line Road   | d  |  |   | 21875                                       |  | USA  |  |
|                                | ems 2   | Funeral        | 11. Marital Status   | 12. Was Decedent Ever in U<br>Armed Forces?                  | .S. 13.  | Was Decedent of Hi                            | ispanic Origin? (Spe<br>an, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)         | 14. Race - Am<br>Black, Whi                  |  |
| 36                             | or it   |                | 1 ☐ Never Married 2 ☒ Married  | 1 X Yes 2 No<br>If Yes, Give                                 |  | 1 □ Yes 2 No                                  | Specify:                                    |  | Canaifu                                      |  |
| Ö                              | filed within 72 hours after death with the Maryland<br>Hygiene.<br>Hygiene "natural", or items 23a or 28a-f show<br>wher than "natural", or items 23a or 28a-f show<br>ant, the Medical Examiner must be notified at                    | ed by          | 3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ                                      | Year or Dates: 141-4   |  | dent's Usual Occupa                           | ation                                       | unk 1                                    | 6b. Kind of Business                         | Lack   |
| 7.                             | nin 72<br>n "na<br>Medic  | plet           | (Specify only highest grade<br>Elementary/Secondary (0-12)                         | College (1-4or 5+)   | (Give  | kind of work done of<br>DO NOT use retired    | during most of worki<br>f)                  | ing                                      | Tob. Talla of Basilloss                      | windustry  |
| 212                            | d with<br>giene<br>er tha<br>the I  | mo.            | 12   | 0<br>0   |  |   |   | ]  | Delmarva H                                   | Power  |
| 2                              | be file<br>tal Hy<br>d oth  | Be Completed   | 17. Father's Name (First, Middle, Last)  |  |  |   | 18. Mother's Name                           |  | *  |  |
| ₹                              | should be and Mental some marked o  | ဠ              | Raymond H. Gordy   |  | 1  |   | Fannie M                                    |  |  |  |
| ā<br>Z                         | d2sh<br>thanc<br>:7 is n<br>traun   |                | 19a. Informant's Name/Relationship (Typ. Nora E. Gordy/spou                        | ,  | I .  |   | and Number or Rura<br>Road Del              |  | City or Town, State, 21875                   | Zip Code)  |
| ā,                             | s 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at |                | 20a. Method of Disposition   |  | _1   | sition (Name of<br>matory or other place      |   |  | 20c. Location - City or                      | Town, State  |
| E                              | 0 0   |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re<br>4 【XDonation _ 5 ☐ Other (Specify)              | emoval from State  | cemetery, crer   | natory or other plac                          | ;e)   |  |  |  |
| Baltimore, Maryland 21215-0036 | permit. Pag<br>Department<br>Important: I<br>any Injury o   |                | 21. Signature of Funeral Pryice License  | ad Director  | 22   | Name and Addres                               | ss of Facility                              | d 655 W.                                 | Baltimore                                    | e Street   |
| m                              | 9 9 E E 9   | 0 0            | 1 Sound 111  | Mel  |  | Baltimore                                     | MD 212                                      | 01                                       |  |  |
| ۲.                             |   |                | 23a. Part1. Enter the disease, or complite shock, or heart failure. List only on   | cations that caused the deat<br>e cause on each line.        | h. Do not ent  | er the mode of dyin                           | g, such as cardiac                          | or respiratory arre                      | st,  | Approximate<br>Interval Between<br>Onset and Death |
| 1                              | Physician /Medical  |                | Immediate Cause (Final disease or contion resulting in death)                      |  | SCISIS   | •   |   |  |  | A CONTRACTOR OF THE POSITION                       |
|                                | Examiner  |                |  | Due to (or as a conseq                                       | uence of):   |   |   |  |  |  |
|                                |   | er             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a conseq                                       | uence of):   |   |   |  |  |  |
|                                | cuted<br>nd<br>ransit   | Examiner       | that initiated events  |  |  |   |   |  |  |  |
| ,<br>0                         | e exe   |                | resulting in death) Last   | Due to (or as a conseq                                       | uence of):   |   |   | · .                                      |  |  |
| 68760                          | ificate be executed<br>g physician and<br>as the burial-transit   | edical         | d  | ·  |  |   |   |  |  |  |
| _                              | certific<br>ding p  | /Me            | IF FEMALE:   | 3c. If yes, outcome pf pregna                                | ancv   |   |   |  | 001.0  |  |
| ROX                            | death certifi<br>e attending<br>id for use as   | cian           | in the past 12 months?   | 1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of d         | ldeath 3□  | Ectopic pregnancy Other (specify)             | 1   |  | 23d. Date of de<br>Month                     | Day Year   |
| o.                             | 0 0   | Physician/M    | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 9□Unknown  |  | 2 0 1110 (47 0 117)                           |   |  |  |  |
| a,<br>J                        | The law requires that the te has been signed by the sage 2 should be detache  | by P           | Part II. Other significant conditions con  | tributing to death but not res                               | ulting in the ur   | nderlying cause give                          | en in Part I.                               | 23e. Did tob                             | acco use contribute t                        | o the cause of death?                              |
| ğ                              | equire<br>en siç<br>ould b  |                | Acco   |  |  |   |   | 1 □ Ye                                   | s 2. 1                                       | robably 4 □Unknown                                 |
| Vital Records,                 | law r<br>las be   | Completed      | itw  |  |  | <del> </del>                                  |   | 24a. Was an                              | 24b. Were a                                  | utopsy findings available completion of cause of   |
| E<br>E                         |   | Con            |  |  |  |   |   | perform                                  | ned? death?                                  |  |
| <u> </u>                       | sician<br>certifi<br>rector   | Be             | 25. Was case referred to medical examiner?   | ospital:   |  | t 30 DOA Othe                                 | 26. Place of Death                          |  |  |  |
| Ö                              | Physer this sral di   | To             | 27. Manner of Death  | 28a. Date of Injury  | ER/Outpatien<br>28b. Time of   | 1 3 DOA                                       | 4 □ Nursing Ho                              | me 5 ☐ Resider<br>28d. Describe ho       | nce 6 Other (Spe<br>w injury occurred        | ecify)   |
| <u>0</u>                       | nding<br>ith.<br>r: Afte<br>e fune  | tior           | 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation                                 | (Month, Day Year)  | Injury   |   | k?<br>Yes 2 □ No                            |  |  |  |
| DIVISION OF                    | r Atte<br>er dea<br>recto<br>by th  | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined                               | 28e. Place of injury - At he building, etc. (Specif          |  | eet, factory, office                          |   | 28f. Location (Str.<br>City or Town,     | eet and Number or F                          | dural Route Number,                                |
| 5                              | ital or<br>irs after<br>ral Di  | Cer            |  |  |  |   |   |  |  |  |
|                                | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification completely filled in by the funeral director,   | edical         | 29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin                | ician: To the best of my kno<br>ier: On the basis of examina | wledge, death<br>ition and/or in   | n occurred at the tin<br>vestigation, in my o | ne, date and place,<br>pinion, death occur  | and due to the ca<br>red at the time, da | use(s) and manner a<br>ate and place, and du | s stated.<br>e to the cause(s)                     |
|                                | o the<br>ithin 2<br>o the<br>omple  | Med            | 29b. Signature and title of certifier  | and manner stated.   |  | 29c. License                                  | e number                                    | 29                                       | d. Date signed (Mon                          | th. Dav. Year)                                     |
| i                              | F ≯ F ŏ   |                | ME   |  |  | H50   | 1497  |  | 8/6/07                                       |  |
|                                |   |                | 30. Name and address of person who con   |  |  | Print)  |   |  |  |  |
|                                |   |                | Chris Snyde  |  |  |   | alisky                                      | WO 21                                    | 801  |  |
| 1                              | Sta   |                | 31. Date filed (Month, Day, Year)  | 100 E Carro<br>32 Aegistrar's Signa<br>7 May A               | ature  | وتكمع   |   |  |  |  |
|                                | Registr   | ar             | AUG 1 4 200  | 1 JETHAN S.  | The same of the sa |   |   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per ab 9870 8-16-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month august 23:40 M David Greenwood 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Dave Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1**X** M 2□F 214-64-3449 55 Jan 8, 1952 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No MD Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7851 Crilley Road #505 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) stock clerk grocery store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Marcy A. Dickerson John Greenwood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda S. Greenwood/spouse 7851 Crilley Road #505 Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 Mother (Specify) in state 21. Si nature of Funeral Stryice License Wade State Anatomy Board 655 W. Baltimore Street Dixector Baltimore, MD 21201 23a. Part 1. Enter the disease or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or his condition resulting in death) Approximate Interval Between Onset and Death 2 months Due to (or is a con squence of): Sequentially list conditions, if any, leading to immediate cause. Enter or derlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

**Physician** /Medical **Examiner** 

certificate be executed

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician;

permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien. Important: If item 27 is marked other the any Injury or other traumatic event, the jonce.

Physician

/Medical

Examiner

10a. State

Director

Funeral

2

Completed

Be

2

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

death with the Maryland

within 72 hours after

Baltimore, Maryland 21215-0036

attending physician for use as the buria

Examine Physician/Medical Completed within 24 hours after death.

To the Funeral Director: After to completely filled in by the funera

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

hvisty Tran, D.O

C.Tran, D.O

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

State Registrar

|   | d   |  |   |   |  |
|---|---|--|---|---|--|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome pf pregr<br>1 ☐ Live birth 2 ☐ Fet<br>4 ☐ Pregnant at time of<br>9 ☐ Unknown | al death 3 ☐ Ectopi                            | c pregnancy<br>(specify)                                  |   | 23d. Date of delivery<br>Month Day Year                          |
| Part II. Other significant conditions   | contributing to death but not re  | sulting in the underlyin                       | g cause given in Part I.                                  | 23e. Did tobacc   | co use contribute to the cause of death?                         |
|   |   |  |   | 24a. Was an autopsy performed                             |  |
| 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No                              | Hospital: 1 Inpatient 2   | ]ER/Outpatient 3□                              | Othor   | Death (Check only one)                                    | 6 □Other (Specify)   |
| 27. Manner of Death  1 Matural 5 ☐ Pending 2 ☐ Accident investigatio                    | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of Injury                            | 28c. Injury at Work?                                      | 28d. Describe how in                                      |  |
| 3 Suicide 6 Could not b<br>4 Homicide determined  |   | nome, farm, street, fac                        | tory, office  | 28f. Location (Street<br>City or Town, St                 | and Number or Rural Route Number,<br>ate)                        |
| 29a. Certifler 1 Certifying P (Check only one) 1 Medical Exa                            | hysician: To the best of my kn<br>miner: On the basis of examin<br>and manner stated.             | owledge, death occur<br>ation and/or investiga | red at the time, date and p<br>tion, in my opinion, death | place, and due to the cause<br>occurred at the time, date | e(s) and manner as stated.<br>and place, and due to the cause(s) |
| 29h Signature and title of cortifier  |   |  | 29c License number  | 204   | Date signed (Month Day Year)                                     |

29c. License number

AT-2438946

29d. Date signed (Month, Day, Year)

august 4, 2007

Union Memorial Hospital, MD, 2018. University

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend #1.perMD,g870, 8/14/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Calvin Lee Horton 2. Date of Death 3. Time of Death 2007 **Physician** Va /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOSPITAL KACTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Davs Hours Min. 1 X M 2□ F 215-46-6392 Hereford CO. NC Director Aug 07, 1947 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at Baltimore 1 Yes 2 No Funeral Director MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 5. 12. Was Decedent Ever in U.S. Armed Forces?

1 M Yes 2 □ No If Yes, Give 7 2 2 12 ural", or items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Black 3 Widowed 4 Divorced "natural" Completed th and Mental Hygiene.

77 Is marked other than "nature traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenace worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Dessoms Horton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mc Bride MD Alberge Balto, Health tem 27 I Sharon Ln 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or conce. 1 Burial 2 Cremation 3 Removal from State Forest Vet Cem 8 Owings Mills -14-2007 4 Donation 5 Dother (Specify) 21. Signatur 22. Name and Address of Facility 814 Upshur St NW. Web DC. Uts W. Hac Approximate Interval Between Onset and Death rt1. Ent r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hook, or leart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Land United Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Division or Vital Records, P.O. Box 68760,  $ot\in$ The law requires that the death certificate be execu Due to (or as a consequence of): Physician/Medical the attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaeco use contribute to the cause of death? ģ NEURONIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1∐ Yes To the Hospital or Attending Physician; 25. Was case referred to medical examiner? filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident 3☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. Pate signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTINONE 3.01 ST. 212)5 JOS EPAM 31. Date filed (Month, Day, Registrar's Signature State Registrar

| /Vojcie  | ech Helink  |                            | 1- For State   | Sta                    | ate of Marylan  |                   | rtment of<br>tificate of |   | Mental H             |                             | eg. No.   | 0:02   |
|----------|---|----------------------------|--|------------------------|---|-------------------|--------------------------|---|----------------------|-----------------------------|---|--|
|          | Physici   | an/                        | Registrar  1. Decedent's Name  | (First, Middle         | e,Last)   |                   |                          |   |                      | 2. Date of Dea              | th A - N  | 3. Time of Death   |
| Medic    | cal Exami   | ner                        |  |                        | rt Helinsk  |                   |                          | lb. City, Town, or L                      | ocation of Dea       | Month<br>August 11          | , 2007<br>4c. County of D                       | 1755 hrs   |
|          |   |                            | Shady Grove  |                        | , give street and nome  | ,,,               |                          | Rockville                                 | ocation of Bee       |                             | Montgome  |  |
|          | Funeral   |                            | 5. Social Security Nu  | umber                  | 6. Sex 7.   | Age (In yrs. la   | st birthday)             | If Under 1 Year<br>Months Days            | If Under 24H         |                             |   | . Birthplace (State or<br>preign                             |
|          | Director  |                            | 223-97-48  |                        | 1 X M 2 F   | 32                | Yrs.                     | Months Days                               | Hours                | 02/28/                      | 1975  | Country) Poland  |
|          | any.  |                            | Usual Residence of I<br>10a. State 1   | Decedent<br>0b. County |   | 10c. City,        | Town or Locati           | on  |                      |                             |   | 10d. Inside City Limits                                      |
|          | <u>*</u> .  | 'n                         | Poland   | Lube                   | lski  | Lut               | olin                     |   |                      | 0.33 to                     |   | 1 X Yes 2 No   |
|          | Maryla<br>- 28a-f<br>d at o   | Director                   | 10e. Street and Num  | ber                    |   |                   |                          | 10f. Zip Code                             | 2                    | 1                           | 0g. Citizen of What                             | Country?   |
|          | th the<br>23a or<br>notifie   | al Di                      | U1. Dziall   | kowa 4                 |   | ant Francis III 6 | 2 142 144-               | 20–121                                    | 0 /                  |                             | oland   | marinan Indian Block   |
|          | Pages 1 and 2 should be filed within 72 hours after death with the Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland unt: If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at once.   | uneral                     | Never Married  | d 2 <b>X</b> Ma        |   |                   |                          | s Decedent of Hisp<br>es, specify Cuban,  |                      |                             | White, et                                       | merican Indian, Black,<br>tc.                                |
| _arrespe | after d<br>al", or<br>iner m  | by Fi                      | 3 Widowed  |                        | orced If Yes, Give Year or Dates:                                     |                   | 1                        | Yes 2 X No                                | specify:             | 34.                         | Specify: W                                      |  |
|          | led within 72 hours after Hygiene.  other than "natural", the Medical Examiner.   | ted t                      | 15. Decedent's Edu<br>Elementary/Secon   |                        | College (1-4  |                   |                          | t's Usual Occupationst of working life.   |                      |                             | 16b. Kind of Busine                             |  |
| 36       | thin 72<br>than than edical   | Completed                  | 12   | idaly (0-12)           | College (1-4  | 01 5+)            | Area                     | Manager                                   | 300                  |                             | Pool Man<br>Company                             | agement  |
| 5-0036   | Hygien<br>I other<br>the Me   |                            | 17. Father's Name (F   | irst, Middle,          | Last)   |                   |                          |   | 8.Mother's Nar       | me (First, Middle,          | Maiden Surname)                                 |  |
| 2424     | should be filed vand Mental Hygi  | o Be                       | Stanisla<br>19a. Informant's Nan   |                        |   |                   | 10h Mailine              | Address (Street                           |                      | ta Kostk                    |   | State, Zip Code) 20895                                       |
| Z CIN    | and 2 shoul<br>ealth and N<br>tem 27 is n<br>traumatic  | ř                          |  |                        | Legal Spon  | sor               |                          |   |                      | -                           |   | ington, MD   |
| 9        | es I and 2<br>of Health<br>If item 2<br>her traum   |                            | 20a. Method of Dispo   | osition                |   | 20b. P            | lace of Dispos           | ition (Name of cerr                       | etery,               | Date                        | 20c. Location - Cit                             |  |
| altimore | Pages<br>nent of<br>ant: I  |                            | 1 Burial 2 Donation 5  |                        | 3 X Removal from ecify:   | Cme               | ntarz                    | na Majdar                                 | ıku 08               | /21/2007                    | Lublin,   | Poland   |
|          | permit. Page Department of Important: injury or oth   |                            | 21. Synam 3 Fun  |                        |   |                   | 22. N                    | ame and Address<br>DId Town<br>205 Bellio | of Facility Funera   | L Choice:                   | S<br>lexandria                                  | , VA 22307   |
|          | hysician  | _                          | 23a. Part I. Enter the failure. List only  | disease, or o          | complications that cau  | sed the death.    |                          | _   |                      |                             |   | Approximate Interval<br>Between Onset and                    |
|          | /Medical xaminer  |                            | Immediate Cause (F   | inal disease           | a. Probable   |                   |                          |   |                      |                             |   | Death  |
|          | :   |                            | or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  Primary brain tumor complicated by drowning |                        |   |                   |                          |   |                      |                             |   |  |
|          |   | iner                       | teach teaching to timinediate Due to (or se a consequence of):   |                        |   |                   |                          |   |                      |                             |   |  |
|          | ±   | xam                        | (Disease or injury the events resulting in d   | at initiated           | Due to (or as a co  | onsequence of)    | ):                       |   |                      |                             |   | -  |
|          | cecuted<br>and<br>ransit  | a<br>E                     | Text)  | _                      | d   |                   |                          |   |                      |                             |   |  |
| 9        | nte be exe<br>hysician<br>e burial -  | Physician/Medical Examiner | X UNPENDED   |                        | #23a-b,2  | 7,28-f,           | perME,g8                 | 71, 9/27/07                               | 7 TT                 |                             | 23d. Date of del                                | livor.   |
| 3876     | OX 68/6<br>eath certificate<br>attending phy<br>for use as the t  | an/N                       | 23b. Was decedent p<br>past 12 months?   |                        | I I LIVE DILL   | 1                 | <sub>2</sub> Fe          | tal death 3                               | Ectopic preg         | nancy                       | Month Month                                     | Day Year   |
| Boy 687  | eath ce<br>attenc<br>for use  | /sici                      | 1 Yes 2 No   |                        |   | t at time of dea  | ath 5 Otl                | ner (Specify)                             | · · · · · ·          |                             |   |  |
|          | at the d<br>by the<br>tached  |                            | Part II. Other signifi   | cant condition         | ons contributing to d   |                   | sulting in the u         | nderlying cause gi                        | ven in Part I.       | 23e. Did t                  | obacco use contribut                            | te to the cause of death?                                    |
| ۵        | ires the  | d by                       |  |                        |   |                   |                          |   |                      | 1 Ye                        | s 2 No 3  | Probably 4 Unknown   |
| ş        | UIVISION Of VITAL RECORDS, P.O. BOX 68/60, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans. | Completed                  |  |                        |   |                   |                          |   |                      | 24a. Was<br>auto            | osy prio  | re autopsy findings available<br>r to completion of cause of |
| Rec      |   | E O                        |  |                        |   |                   |                          |   |                      | 1 ✔ Yes                     | rmed? dea<br>2 No 1 ✔                           | Yes 2 No   |
| <u></u>  | ician: The l<br>s certificate l<br>rector, page   | Be                         | 25. Was case referre examiner?   | ed to medical          | Hospital:   | atient 2          | ED/Outration             | 10  | of Death (Checother) | ck only one)<br>sing Home 5 | Desidones 6 (                                   | Other:   |
| )<br>}   | g Phys<br>frer this<br>neral di   | <u>ا:</u>                  | 1 ✓ Yes 2<br>27. Manner of Death   | No                     | 28a. Date of  | Injury            | 28b. Time of I           |   | y at Work?           |                             | Residence 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | Julei.   |
| 2        | tendin<br>eath.<br>or: A<br>the fur   | atior                      | 1 Natural 2 X Accident   | 5 X Pendi              | ing (Month, D   | · · ·             | unk                      | 1 Y                                       | es 2 X No            | subject                     | drowned   |  |
| i.       | tal or At<br>rs after d<br>al Direc<br>led in by  | Certification:             |  |                        | not be  |                   | me, farm, stree          | et, factory, office bu                    | uilding, etc.        | 28f. Location (<br>or Town, |   | or Rural Route Number, City                                  |
|          | Hospital or Attend<br>24 hours after death<br>Funeral Director:<br>etely filled in by the   |                            | 4 Homicide   |                        | mined (Specify)   |                   |                          |   |                      |                             | River Montgo                                    |  |
|          | To the Ho<br>within 24 P<br>To the Fu<br>completely   | Medical                    |  |                        | ysician: To the best on<br>niner:On the basis of a<br>and manner stat | examination an    |                          |   |                      |                             |   |  |
|          | 7 × 5   | Me                         | 29b. Signature and ti  | itle of certifier      |   | eu                |                          | 29c. License                              | number               |                             | 29d. Date signed                                | (Month, Day, Year)   |
|          |   |                            | hi   | 7 4                    | v. mid  |                   |                          | O.C.N                                     | Л.Е.                 |                             | August 12, 20                                   | 007  |
|          | 5   |                            | 30. Name and addres  |                        | who completed cause<br>nt Medical Exami                               |                   |                          | t, Baltimore, N                           | ИD 21201             |                             |   |  |
|          |   | ate                        | 31. Date filed (Month  | Day Year).             | 2007 32 Regis   | strar's Signatur  | Local                    | le le                                     |                      |                             |   |  |
|          | Regist  | TELL                       | AL   | A T T                  | FOO! NOW  | 7-                |                          |   |                      |                             |   |  |

|                               |  |                | for State  | State of                             | of Marylar                                     |   |  |                                      |               | •                               | 61 6                              | a for my         | 0.000  |
|-------------------------------|--|----------------|--|--------------------------------------|--|---|--|--------------------------------------|---------------|---------------------------------|-----------------------------------|------------------|--|
| K.                            | -  |                | Registrar  1. Decedent's Name (First, Middle, Last)  |                                      |  |   |  | rtificate of Death                   |               |                                 | Reg. No.  Death  3. Time of Death |                  |  |
|                               | Physici  |                | Powerly D Hacker   |                                      |  |   |  | Mor                                  |               |                                 | Day<br>12                         | Year 2007        | 10:25 p <sup>M</sup>                           |
|                               | /Medio   |                | Beverly P. Hacker  4a. Facility Name (If not institution, give street and number)                          |                                      |  |   |  | 4b. City, Town, or Location of Death |               |                                 |                                   | nty of Death     | 10:25 P  |
| 1                             | Examin   | lei            | Laurel Regional Hospital   |                                      |  |   |  | irel                                 |               |                                 | Prince George's                   |                  |  |
|                               | Funeral  |                |  | 6. Sex                               | 7. Age (In yrs.                                | . last birthday)                            | If Under 1 \                                     | ear If Und                           | der 24 Hrs.   | 8. Date of Bir<br>(Month, Da    | th<br>V Vear                      | 9. Birthp        | place (State or Foreign                        |
| 494.65                        | Director   | , 1            | 402-28-1171  | <b>X</b> XM 2□ F                     | 85   | Yrs.  | Months   | ays Hour                             |               | Nov. 5                          |                                   | Kenti            |  |
|                               | and *  |                | Usual Residence of Decedent  10a. State 10b. County  |                                      | 10c. Ci  | ity, Town or Lo                             | cation   |                                      |               |                                 |                                   |                  | 0d. Inside City Limits                         |
|                               | Marylis<br>f sho<br>ed at  | ō              | MD Howar   | - A                                  |  | aurel                                       |  |                                      |               |                                 |                                   |                  | 1 ☐ Yes 2√ No                                  |
|                               | the 128a-  | Director       | 10e. Street and Number   | 4                                    |  | durci                                       | 10f. Zip Co                                      | de                                   |               |                                 | 10g. Citizen o                    | of What Cour     | **   |
|                               | 3a or  | 0              | 8726 Teresa La   | .ne                                  |  |   | 20   | 723                                  |               |                                 |                                   | USA              |  |
|                               | filed within 72 hours after death with the Maryland<br>Hygiene.<br>wher then "natural", or items 23a or 28a-f show<br>ant, the Medical Examiner must be notified at  | Funeral        | 11. Marital Status   | 12. Was Dec                          | cedent Ever in U                               | J.S. 13. \                                  |  | of Hispanic                          | Origin? (Spe  | ecity Yes or No                 |                                   | Race - Americ    |  |
| 9                             | after<br>or ite  | / Fu           | 1 ☐ Never Married 2 🔀 Marrie   |                                      |  |   | il⊟Yes 2.[∑                                      |                                      |               | nican, etc.)                    |                                   | Black, White,    |  |
| 8                             | nours<br>ural",<br>Il Exa  | d by           | 3 ☐ Widowed 4 ☐ Divorced   | Year or D                            | lates:   |   |  |                                      |               |                                 |                                   | ******           |  |
| 5                             | n 72<br>"nat<br>edica  | lete           | 15. Decedent's<br>(Specify only highest  | ; Education<br>grade completed)      |  | (Give                                       | lent's Usual C<br>kind of work o<br>OO NOT use r | lone durina n                        | most of worki | ing                             | 16b. Kind of                      | f Business/Ind   | dustry   |
| 72                            | withi<br>iene.<br>than   | Completed      | Elementary/Secondary (0-12)  | College (                            | (1-4or 5+)                                     |   | ey Tra   |                                      |               |                                 | Race                              | e Track          | ζ.   |
| ğ                             | il Hygi<br>other<br>vent, tl   | Be C           | 17. Father's Name (First, Middle, L  | ast)                                 |  |   |  | 18. Mc                               | other's Name  | (First, Middle,                 | Maiden Surn                       | name)            | -  |
| /lar                          | iges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | To E           | Daniel Hacker  |                                      |  |   |  | 2                                    | Sylvan        | ia Her                          | nsley                             |                  |  |
| ar                            | 2 sho<br>and I<br>Is ma  |                | 19a. Informant's Name/Relationshi  | p (Type. Print)                      |  | 19b. Mailin                                 | g Address (S                                     | reet and Nu                          | mber or Rura  | al Route Numb                   | er, City or Tov                   | vn, State, Zip   | Code)  |
| ري ح                          | and<br>lealth<br>m 27<br>her tr  |                | Evelyn Hacker/W  | ife                                  | Look   |   |  |                                      |               | el, MD                          | 20723                             |                  |  |
| altimore, Maryland 21215-0036 | Pages 1<br>ment of H<br>ant: If Ite<br>ury or ot   |                | 20a. Method of Disposition<br>1 ☐ Burial 2 🗷 Cremation   |                                      | State  | Place of Dispo<br>cemetery, cren<br>st Arur | natorý or othe                                   | r place)                             |               | Date                            | _                                 | n - City or To   | own, State                                     |
| ≣                             | it. Pa<br>irtmer<br>rrant:<br>njury  |                | 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service Li  |                                      | \  |   |  |                                      | 8/14/         |                                 | Odento                            | •                |  |
| Ba                            | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.   |                | 21. Signature Puneral service E  | X 120                                | OKM01:   |   |  |                                      |               | aldson<br>, Laure               |                                   | 20707            |  |
|                               |  |                | 23a. Part1. Enter the disease, or of shock, or her rt failure. List of                                     | omplications that only one course on | caused the dear                                | th. Do not ente                             | er the mode o                                    | f dying, such                        | as cardiac o  | or respiratory a                | rrest,                            |                  | Approximate<br>Interval Between                |
|                               | Physician  |                | Immediate Cau (Final disease or condition  | _a. P                                | neumoni  | a   |  |                                      |               |                                 |                                   | 1                | Onset and Death<br>Week                        |
|                               | /Medical<br>Examiner   |                | resulting in death)  |                                      | (or as a consec                                | quence of):                                 |  |                                      |               |                                 |                                   |                  |  |
| E.                            |  | 7              | Sequentially list conditions,  | D.                                   | OPD<br>(or as a consec                         | Tuence of):                                 |  |                                      |               |                                 |                                   |                  | Years  |
|                               | nted<br>nsit   | mine           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unicase of figure |                                      | (01 40 4 5011000                               | 4401100 01).                                |  |                                      |               |                                 |                                   |                  |  |
| Ć,                            | icate be executed<br>physician and<br>s the burial-transit   | Examiner       | that initiated events<br>resulting in death) Last  | c<br>Due to                          | (or as a consec                                | quence of):                                 |  |                                      |               |                                 |                                   |                  |  |
| 8760,                         | te be<br>ysicia<br>ne bur  | dical          | 4  | d                                    |  |   |  |                                      |               |                                 |                                   |                  |  |
| 9                             | rtifica<br>ng ph   | Medi           | IF FEMALE:   | 1                                    |  |   |  |                                      |               |                                 |                                   |                  |  |
| . Box                         | res that the death certifi<br>igned by the attending<br>be detached for use as   | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?  |                                      | tcome pf pregn<br>birth 2 ☐ Feta               |   | Ectopic pregr                                    | ancy                                 |               |                                 |                                   | Date of delive   | ery<br>Day Year                                |
| o.                            | ne deg<br>the a  | /sici          | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4□Preg<br>9□Unkn                     | nant at time of o                              | death 5□                                    | Other (speci                                     | (y)                                  |               |                                 |                                   | MOHILI           | Day Teal                                       |
| <u>.</u>                      | that the sed by detac  | Ph             | Part II. Other significant condition   | s contributing to d                  | leath but not res                              | sulting in the ur                           | nderlying caus                                   | e aiven in Pa                        | art I.        | 23e. Did t                      | obacco use co                     | ontribute to the | ne cause of death?                             |
| Vital Records, P.             | The law requires that the death certifi<br>ite has been signed by the attending<br>page 2 should be detached for use as  | d by           | Cardiomyopath  |                                      |  | enosis                                      |  |                                      |               | 1 🗆                             | Yes 2∐No                          | 3. 3. Prot       | pably 4 ∐Unknown                               |
| Ö                             | w require<br>been sign   | lete           | Congestive He  | art Fail                             | ure  |   |  |                                      |               | 24a. Was                        | an 24                             | h Were auto      | ney findings available                         |
| æ                             | Physician: The lav<br>this certificate has<br>al director, page 2.3  | Completed      | - Jongobouve ne  | are rarr                             | <u> </u>                                       |   |  |                                      |               | auto;<br>perfo                  | rmed?                             | death?           | psy findings available<br>mpletion of cause of |
| ta                            | an: 7<br>tificat<br>tor, p   | Be C           | 25. Was case referred to medical   |                                      |  |   |  | 26. Pl                               | lace of Death | 1  Yes<br>∩ (Check only o       |                                   | 1 □ Yes          | <b>⊉</b> □ No                                  |
| _                             | ysici<br>is cer<br>direc   | To B           | examiner?<br>1 ☐ Yes 🏋 No  | Hospital: 1 💢                        | Inpatient 2                                    | ] ER/Outpatien                              | t 3 DOA  | Other:                               |               | me 5□Resi                       |                                   | Other (Specif    | ······································         |
| 0                             | ng Pł  |                | 27. Manner of Death  Y  Natural 5 □ Pending  | 28a. Date<br>(Mor                    | of Injury<br>oth, Day Year)                    | 28b. Time of<br>Injury                      | 28c.   | Injury at<br>Work?                   |               | 28d. Describe l                 | now injury occ                    | urred            | ·  |
| Sio                           | teridi<br>eath.<br>for A<br>the fu   | catic          | 2 Accident investiga 3 Suicide 6 Could no  | nt ha                                |  |   | М  | 1 ☐ Yes 2                            |               |                                 |                                   |                  |  |
| Division or                   | To the Hospital or Attending Physician: within 24 hours effer death.  To the Funeral Director After this certifics completely filled n by the funeral director,  | Certification: | 4 Homicide determin  | and 200. Place                       | e of injury - At h<br>ling, etc. <i>(Speci</i> | iome, farm, stre<br>ify)                    | et, factory, of                                  | fice                                 |               | 28f. Location (3<br>City or Tox | Street and Nu<br>vn, State)       | mber or Rura     | al Route Number,                               |
|                               | lospita<br>hours<br>uneral   |                | 29a. Certifier 1 X Certifying (Check only 2 Medical E  | Physician: To the xaminer: On the b  | e best of my kn                                | owledge, death                              | occurred at t                                    | he time, date                        | e and place,  | and due to the                  | cause(s) and                      | manner as s      | tated.   |
|                               | the I  | Medical        | one)   | and man                              | nner stated.                                   |   |  |                                      |               |                                 |                                   |                  |  |
|                               | wit 70 cor   | -              | 29b. Signature and title certifier   | MA                                   | ///  | MIT   | )   29C. LI                                      | cense numbe                          | 95-3          | 7                               | 29d. Date sig                     | 1                |  |
|                               | 9  | 1              | 20 Name and Address of   | 1110                                 |  | m 20s) /T                                   | 3-:  | レノ                                   | 1) )          |                                 | Mude                              | 24 12            | 3,2007   |
| 4                             | 10   |                | 30. Name and ddress of poon w<br>Timothy McClai  |                                      | ,  | m 23a) (Type, I<br>nce Geo                  | ,  | reet.                                | Laure         | l, MD                           | 20707                             |                  |  |
| Í                             | Sta  | te             | 31. Date filed (Month, Day, Year)  |                                      | gistrar's Signa                                |   |  | •                                    |               |                                 |                                   |                  |  |
|                               | Registr  | ar             | AUG 1 4  | 2007                                 | leeve.   | 15 Al                                       | and I  |                                      |               |                                 |                                   |                  |  |

07-06079 Kimberly Hiebler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2017 25036 1- For State Certificate of Death Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death Date of Death Physician/ Month 0549 hrs August 8, 2007 ুবা Examiner Kimberly Hiebler 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore N/A Union Memorial Hospital Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Foreign Months Days Hours Country Maryland Director Feb 18. 1972 218-11-9433 1 M 2 X F 35 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No s 23a or 28a-f show : e notified at once. Baltimore Maryland N/A Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21211 3631 Elm Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11 Marital Status White, etc. Armed Forces? Never Married 2 Married 2 X No Yes Specify: White If Yes, Give Year 4 X Divorced 1 Yes 2 X No specify: Widowed traumatic event, the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages I and 2 should be filed within 72! nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "n prother traumatic event, the Medical E. Plumbing Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nancy E. Robinson Be Kenneth H. Hiebler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 503 Valcour Road Catonsville, Maryland 21228 Kenneth H. Hiebler, Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Removal from State 1 X Burial 2 Cremation 3 Catonsville, Maryland 08/11/07 Department o Important: injury or oth Old Salem Cemetery Donation 5 Other Specify: 22. Name and Address of Facility MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, 21. Signature of Funeral Service Licensee Maryland 21228 Gregor 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Death 'ledical Cardiac arrhythmia Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of)

∡aminer The law requires that the death certificate be executed Box 68760,

or items

"natural",

Baltimore, MD 21215-0036

and transit physician the burial been signed by the attending should be detached for use as t After this certificate has Comp within 24 hours after death.

To the Funeral Director:
completely filled in by the f

Division of Vital Records, P.O.

To the Hospital or Attending Physician:

| Ä            | events resulting in deathy Last   |   |    |                         |         |         |
|--------------|---|---|----|-------------------------|---------|---------|
| dical        | d. X UNPENDED   | #ENDED<br>#23a,27,perME,2872, 10/24/07 TT   |    | Lag L D is a Cal        |         |         |
| hysician/Me  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ✔ Unknown | 23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnan 4 Pregnant at time of death 5 Other (Specify) 9 Unknown | су | 23d. Date of d<br>Month | Day Day | Year    |
| leted by Phy | Part II. Other significant conditions   | contributing to death but not resulting in the underlying cause given in Part I.  |    |                         |         | Unknown |

| O                   | 25. Was case referred to medical  | 26.Place of Death (Check only one)  |  |   |  |  |  |  |  |
|---------------------|---|---|--|---|--|--|--|--|--|
| ertification: To Be |   | spital: 1 Inpatient 2 🗸 ER/Outpatient 3   | ng Home 5 Residence 6 Other:                                     |   |  |  |  |  |  |
|                     | 27. Manner of Death  1 X Natural 5 Pending                                  | 28a. Date of Injury<br>(Month, Day, Year) 28b. Time of Injury   | 28c. Injury at Work?  1 Yes 2 No                                 | 28d. Describe how injury occurred   |  |  |  |  |  |
|                     | 2 Accident Investigation 3 Suicide 6 Could not be determined                | 28e Place of Injury - At home, farm, street, fa   | ctory, office building, etc.                                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                        |  |  |  |  |  |
| dical C             | 29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner:0 | To the best of my knowledge, death occurred and the basis of examination and/or investigation, and manner stated. | at the time, date and place, an<br>in my opinion, death occurred | d due to the cause(s) and manner as stated.<br>at the time, date and place, and due to the cause(s) |  |  |  |  |  |
| Me                  | 29b. Signature and title of certifier                                       | ma marmor states.   | 29c. License number  | 29d. Date signed (Month, Day, Year)   |  |  |  |  |  |

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner Zabiullah Ali, M.D.

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

31. Date filed (Month Day, Year) 2007 Registrar

Registrar's Signatur

OCME

✓ Yes 2

No

August 8, 2007

2

1 🗸 Yes

Registrar
DHMH 17 Rev 1/2001

State

17-24-167

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Margaret Month Ouinn Huppmann 0600 An /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death nes HOSPITAL RE 5. Social Security Number 6. Sex Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2 🗗 F Months Davs Hours Min. 212-22-7720 83 Director 12-23-1923 MD Usual Residence of Decedent 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov idical Examiner must be notified at Director Md. 1 ☐ Yes 2X No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Montrose Avenue 21228 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Bace - American Indian Black, White, etc. within 72 hours after 1 ☐ Yes 2 1 ☐ Yes, Give Year or Dates: 1 ☐ Never Married 2 Harried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: φ 3 ☐ Widowed 4 ☐ Divorced Specify: white Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumation. Elementary/Secondary (0-12) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Alexander Quinn Mary Magdalene Schreiber 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul H. Huppmann, husband 110 Montrose Ave., Catonsville, Md. 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 8/9/2007 4 □ Donation 5 □ Other (Specify) Catonsville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a conse ue ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 attending physician for use as the buris Physician/Medical IF FEMALE: f yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) Day 4□Pregnant at time of death 9 ☐ Unknown eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes or Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Certification: To 1 🔲 Yes 1 Dinpatient 2 ER/Outpatient 3□ D0A 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a e Funeral I 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

F

MARGARE

The Perane

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

>22T

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Year Arthur William Hesse 2007 9:35 A Aug 10, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 5201 Brinkley Road Clinton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Months M 2□ F 1923 Wisconsin Director 84 395 16 4609 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show if item 27 is marked other then "natural", or items 23s or 28s-f ebov or other traumatic event, the Madical Examinat must be notified at 1 Yes 2 No Be Completed by Funeral Director Temple Hills Prince George's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20748 United States 5201 Brinkley Road 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1√RYes 2□No WWII IFYes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√XNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Airforce U.S. Government 4t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Phiel Augusta Martin Hesse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: if item 27 is eny injury or other trac 5201 Brinkley Road, Temple Hills, MD 20748 Charlotte M. Hesse (WIFE) 20a. Method of Disposition

2 Dremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Arlington National Cemetery 4 □Donation 5 □ Other (Specify) Arlington, Virginia 21. Signature of Funeral 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac Hvv hythmia **Physician** 3mms /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3. Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 🗍 Unknown 1 ☐ Yes Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No oglaous certificate 2 No 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, i 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 1 Yes 2 No Medicai Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home XX Residence 6 ☐ Other (Specify) 27. Mann 1 Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 2 No 1 TYes 2 Accident investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD\_10 St. Patricks Drive # 203, Waldorf, MD Richard A. Farson, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 4 2007 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Muriel Virginia Holbrook Ce, 2007 1:52 A August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Carrell meytown Shepherd's Gren Assisted LIMO If Under 1 Year | If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🛱 F Months Days Hours Min. 216-10-7109 1915 Aug 19, Usual Residence of Decedent 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No Carrol1 Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4949 Middleburg Road 21787 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify white 3 XWidowed 4 □ Divorced unk 15. Decedent's Education (Specify only highest grade completed) unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) unk 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shepherd's Glen Asst Living 4949 Middleburg Road Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 X Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Board 655 W. Baltimore Street Anatomy nore, MD State Anat Baltimore, Enter the disease that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cause on each line Immediate Casse (Final disease or condition resulting in death) erzioral Days Due to (or as a consequence of)

Physician /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a State

MD

Director

by Funeral

Completed

Be ၉

**Funeral** 

Director

ortant: if item 27 is marked other than "netural", or items 23e or 28e-f show injury or other traumatic event, the Madical Examination invalue in Adminstration

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If them 27 is marked other than "netural", or flen any injury or other traumatic avant.

Baltimore, Maryland 21215-0036

the Maryland

death with

Examiner attending physician for use as the buria Physician/Medical þ Completed Be J<sub>0</sub> Certification: after death.

Director: Aft

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

After t

within 24 hours a To the Funeral I

Division of Vital Records, P.O. Box 68760,

| dicai Examiner        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Lisease or injury that initiated events resulting in death) Last | b. Due to (or as a consequence of Due to (or as a consequence of d.                                | ,  |  |   |   |
|-----------------------|---|--|--|--|---|---|
| by Physician/Medicai  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown | 3 ⊟Ectopic pregr<br>5 □ Other (specia        |  |   | 23d. Date of delivery  Month Day Year   |
| Completed by P        | Part II. Other significant conditions of  | contributing to death but not resulting in t   | he underlying caus                           | se given in Part I.                                |   | use contribute to the cause of death?  No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Ves 2 No |
| Be                    | 25. Was case referred to medical examiner?  |  |  |  | ath (Check only one)                                    |   |
| 0                     | 1 ☐ Yes 2 ☑ No  | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp  | patient 3 DOA                                | Other: 4 Nursing H                                 | lome 5 - Residence                                      | 6 ☐ Other (Specify)   |
|                       | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation  | n  | me of 28c.<br>iury M                         | Injury at<br>Work?<br>1 Tyes 2 No                  | 28d. Describe how inju                                  | ry occurred   |
| edical Certification; | 3 Suicide 6 Could not b 4 Homicide determined   |  | n, street, factory, of                       | ffice  | 28f. Location (Street ar<br>City or Town, State         | nd Number or Rural Route Number,<br>a)  |
| edical                | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Exar   | nysician: To the best of my knowledge, on the basis of examination and/<br>and manner stated.      | death occurred at t<br>'or investigation, in | the time, date and place<br>my opinion, death occu | , and due to the cause(s<br>irred at the time, date and | ) and manner as stated.<br>d place, and due to the cause(s)   |
| Š                     | 20h Signature and title of contifier I  |  | 200 1  | ioonea numbor                                      | 20d Da  | te signed (Month Day Vear)  |

1000S9943

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westminster

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

onn

( Asserted

Year)

30. Name and address of

Stroy

person who completed cause of death (Item 23a) (Type, Print)

295

32. Segistrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2604 State of Maryland / Department of Health and Mental Hygiene 🗇 = For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 8:15 PM **Physician** AUGUST 2007 JONES WILLIAM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE NURSING HOME
7. Age (In yrs. last birthday)
F Yrs. PATONSVILLE FUREST HAUEN If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Month, Day Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 5. Social Security Number **Funeral** Months 190-20-9194 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10b. County item 27 is marked other then "neturel", or items 23s or 28s-1 show other freumstic event, the Medical Examiner must be notified at 1 Yes 2 □ No MD 1-timore Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No I¥Yès, Give Year or Dates: 11. Marital Status 72 hours efter 1 Never Married 2 Married Blac1 ☐ Yes 2 No Specify Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
jite. DO NOT use fetired) 15. Decedent's Education (Specify only highest grade completed) withIn Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed with! If Heelth and Mental Hygiane. Th 18. Mother's Name (First, Middle, Maiden Sumame) UNK 17. Father's Name (First, Middle, Last) LINK Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) rina Brooks Baltimore, MD Leithwalk 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition permit. Pages 1
Depertment of H
Important: If Ite
eny Injury or ot Monessen 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signatur of Funeral Pervice Licenses Balton reene 23a, Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart frilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ending physicien end use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No ō 4□Pregnant at time of death 5 Other (specify) P.O. I certificate has been signed by the intector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 Mo 1 ☐ Yes 2 No 25. Was case referred to medical examiner? To the Hospital or Attending Physicien: 26. Place of Death (Check only one) director. Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA ٩ this 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Deal 28a. Date of Injury (Month, Day Year) 28b. Time of Certification; After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director; 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 T Homicide within 24 hours e To the Funeral D Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 W 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

2007

transit the death certificate be executed and physicien and ts the burial-tr of Vital Records, P.O. Box 68760, use as ding atten for u signed by the a d be detached for been si page 2 s certificete After this certific funeral director, death. I Director: / filled in by within 24 hours after To the Funeral Dire 0

**Funeral** 

item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Madical Examinal must be notified at

Hygiene.

Mental

permit. Pages 1 and 2 s
Depertment of Health ar
Importent; If item 27 le
eny injury or other trau

Physician

Examiner

/Medical

5-0036

2121

Maryland

Baltimore,

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Out I W. Monk MD 2195. Washington St. Easton, Md. 21601 32. Registrar's Signature

**ORIGINAL** 

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|          |   |                  | For State Registrar   |                                     | State of Ma                                     | aryland / [                 | Department of<br>Certificate               |                               |                                |                               | giene,<br>Reg. No. | 2007   | 25045  |
|----------|---|------------------|---|-------------------------------------|---|-----------------------------|--|-------------------------------|--------------------------------|-------------------------------|--------------------|--|--|
|          | Dhysisi   | an               |   | ne (First, Middle, La               | ıst)  |                             |  |                               | 2                              | 2. Date of De                 |                    | Year   | 3. Time of Death                                   |
|          | Physici<br>/Medic   |                  | Virgini   |                                     |   |                             |  |                               |                                | 8                             | 9                  | 70   | © 830A M   |
| )        | Examin  | er               | 1   | \ 1                                 | ve street and number)                           |                             | 4b. City, Tov                              | n, or Location                | n of Death                     |                               |                    | County of Death                                  |  |
|          | Funeral   | 236              | 5. Social Security I  |                                     | Sex 7. Age                                      | e (In yrs. last bir         | thday) If Under 1 Y                        | ear If Und                    | er 24 Hrs. 8                   | 8. Date of Bir                | th                 |  |  |
|          | Director  |                  | 215-01-3  | 1747                                | 1□M 2∰F 8                                       | 38                          | Yrs. Months D                              | ays Hours                     | Min. 1                         | 2/15/1                        | 918                | Cot  | nplace (State or Foreign<br>untry)<br>MD           |
|          | w w   |                  | Usual Residence of<br>10a. State  | f Decedent<br>10b. County           |   | 10c. City, Town             | n or Location                              |                               |                                |                               |                    |  | 10d. Inside City Limits                            |
|          | Manyla<br>f sho<br>ied at   | lor              | MD  | Wicomico                            | <b>o</b>  | Salisb                      | urv  |                               |                                |                               |                    |  | 1 □ Yes 2 No                                       |
|          | r 28a-  | irec             | 10e. Street and Nu  | ımber                               |   |                             | 10f. Zip Co                                | de                            |                                |                               | 10g. Citize        | en of What Cou                                   | untry?   |
|          | th with   | al D             | 1109 Sc   | uth Schur                           | maker Dr  |                             | 2180                                       | 4                             |                                |                               | U.S                | S.A.   |  |
|          | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or items 23a or 28a-f show<br>the Medical Examiner must be notified at  | Funeral Director | 11. Marital Status  |                                     | 12. Was Decedent E<br>Armed Forces?<br>1 Yes 2  | Ever in U.S.                | 13. Was Decedent                           | of Hispanic (<br>Cuban, Mexic | Origin? (Spec<br>can, Puerto R | ify Yes or No<br>lican, etc.) | )- 1-              | <ol> <li>Race - Amer<br/>Black, White</li> </ol> |  |
| 0000     | rs afte   | by F             | 1 □Never Mar<br>3 XWidowed  | ried 2 Married 4 Divorced           | 1 ☐ Yes 2 ☐ N<br>If Yes, Give<br>Year or Dates: | 10                          | 1 □ Yes 2                                  | No Specia                     | fy:                            |                               | 3                  | Specify: Wh:                                     | ite  |
| 5        | 2 hou<br>atura<br>cal Ex  |                  |   | 15. Decedent's E                    | ducation  | 16a.                        | Decedent's Usual O                         | ccupation                     |                                |                               | 16b. Kin           | d of Business/l                                  |  |
| 7        | thin 7;<br>e.<br>an "n<br>Medi  | Completed        | Elementary/Sec  | ondary (0-12)                       | College (1-4or 5                                | +)                          | (Give kind of work d<br>life. DO NOT use r | one during m<br>etired)       | ost of working                 | g                             |                    |  |  |
| 7        | ed wii<br>ygien<br>ner th<br>t, the   | Con              | 12  |                                     |   | Ho                          | memaker                                    | T                             |                                |                               |                    | estic  |  |
| <u>a</u> | ould be filed with<br>Mental Hygiene.<br>arked other thar<br>atic event, the M  | Be               |   | (First, Middle, Last<br>Franklin    | •   |                             |  |                               | ther's Name (<br>mie Be        |                               | , Maiden S         | Surname)   |  |
| Ž        | should be<br>ind Mental<br>marked c   | 은                |   | lame/Relationship                   |   | 19h                         | . Mailing Address (Si                      |                               |                                |                               | er City or         | Town State 7                                     | in Code)   |
| Z<br>S   | d2<br>tha<br>7 Is   |                  |   | hew Jones                           |   | I                           | 924 Manns                                  |                               |                                |                               |                    |  | ,, Codo,   |
| je,      | es 1 and 2<br>of Health<br>item 27  <br>r other tra   | -                | 20a. Method of Dis  |                                     | 70 14 611                                       | 20b. Place of cemeter       | Disposition (Name or or other              | of<br>rplace)                 | Da                             | ite                           | 20c. Loc           | ation - City or 1                                | Town, State  |
| Ĕ        | Page<br>ment a  |                  |   | □ Cremation 3 L<br>5 □ Other (Speci | Removal from State                              |                             | y Methodi                                  | st                            | Aug 13                         |                               |                    | nton MD  |  |
| Dallillo | permit. Pages 1 an<br>Department of Heal<br>Important: If item 2<br>any injury or other<br>once.  |                  | 21. Signature of F  | uneral Service Lice                 | •//   |                             | 22. Name and A                             |                               |                                | _                             |                    |  | ne PA  |
|          |   |                  | 22a Parti Enter   | the disease or con                  |   | 61459                       | 1 2nd Av                                   |                               |                                |                               |                    | 1061   | Approximate  |
|          | ©   |                  | shock, or he  |                                     | plications that caused<br>one cause, n each lin | ile.                        | //   |                               | as caldiac of                  | тезрпатогу а                  | nest,              |  | Approximate<br>Interval Between<br>Onset and Death |
|          | Physician<br>/Medical   |                  | disease or condition resulting in death)  | on                                  | a. 75 PIVA                                      | a consequence               | Preumo                                     | nik                           |                                |                               |                    |  | -  |
|          | Examiner  |                  | 0   |                                     | Alak  | ence                        | 's D150                                    | 2630                          |                                |                               |                    |  |  |
| /        | D #   | iner             | Sequentially list of<br>any, leading to<br>cause. Enter Und<br>Cause (Disease o<br>that initiated event | onditions,<br>immediate<br>erlying  | Due to (or as a                                 | a consequence               | oly.                                       |                               |                                |                               |                    |  |  |
| ) D.     | and<br>trans  | Examiner         | Cause (Disease o<br>that initiated event<br>resulting in death)   | r injury<br>is<br>Last              | C   | a consequence               | nf):                                       |                               |                                |                               |                    | -  |  |
| 00,      | icate be executed<br>physician and<br>s the burial-transit  | alE              |   | l                                   |   | a consequence (             | 51).                                       |                               |                                |                               |                    |  |  |
| 000      | ificate<br>g phys   | edical           |   |                                     | d   |                             |  |                               |                                |                               |                    |  |  |
| 5        | sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as   | Physician/M      | IF FEMALE:<br>23b. Was deceded  |                                     | 23c. If yes, outcome<br>1□Live birth            |                             | 3 □Ectopic pregr                           | ancy                          |                                |                               | 23                 | 3d. Date of deli                                 | -  |
|          | e deal  | sicis            | in the past 12  | Z No                                | 4☐Pregnant at                                   |                             | 5 ☐ Other (special                         |                               |                                |                               |                    | Month  | Day Year   |
|          | hat the<br>d by t<br>letach   | Phy              | 9 ☐ Unknown   | '                                   | contributing to death bu                        | ıt nat recultina ir         | the underlying caus                        | a diven in Pa                 | rt I                           | 23a Did 1                     | abacco us          | a contribute to                                  | the cause of death?                                |
| Ď,       | signe<br>d be c   | d by             | Tartin Other Sign   | mount containons                    | ooning to doding                                | at not resulting in         | Ture underlying dads                       | o giveiriir i ai              | 11.12                          | 1 🗆                           |                    | ,  | bably 4 □Unknown                                   |
| SOLOS,   | w requ  | Completed        |   |                                     |   |                             |  |                               |                                | 24a. Was                      | an                 | 24h Wara aut                                     | topsy findings available                           |
| ב<br>כ   | The lay   | dmc              |   |                                     |   |                             |  |                               |                                | auto                          | psy<br>prmed/?     | prior to c<br>death?                             | ompletion of cause of                              |
| g        | lan: 7  | 0                | 25. Was çase refe   | rred to medical                     |   |                             | ·  | 26. Pia                       | ace of Death                   | 1□ Yes<br>(Check only o       | No No              | 1 □ Yes  | 2/2110   |
| >        | hysicl<br>his ce<br>I direc   | To B             | examiner?<br>1 □ Yes  | ₩0                                  | Hospital: Inpatie                               | nt 2 ☐ ER/Ou                | tpatient 3 DOA                             | Other:                        |                                |                               |                    | □Other (Spec                                     | eify)  |
| 5        | ing P   |                  | 27. Manner of Dea   | th<br>5 ☐ Pending                   | 28a. Date of Injur<br>(Month, Day               | ry 28b. 7<br><i>Year)</i> 1 |  | Injury at<br>Work?            |                                | Bd. Describe                  | how injury         | occurred   |  |
| 2        | ttend<br>death.<br>stor: /<br>the f   | icati            | 2 ☐ Accident<br>3 ☐ Suicide   | investigatio<br>6 ☐ Could not b     | e 28e Place of inju                             | Inv. At home fo             | rm, street, factory, of                    | 1 ☐ Yes 2                     |                                | Of Logation (                 | Ctmat and          | Mumbar or Pu                                     | m I Pouto Alumbor                                  |
| 2        | lor A<br>after<br>Direc   | Certification:   | 4 ☐ Homicide  | determined                          | building, etc                                   | c. (Specify)                | im, street, factory, or                    | lice                          | 20                             | City or To                    |                    | Number of hu                                     | ral Route Number,                                  |
|          | To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death, within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as |                  | 29a. Certifier<br>(Check only   | Certifying P                        | hysician: To the best of miner: On the basis of | of my knowledge             | e, death occurred at t                     | ne time, date                 | and place, ar                  | nd due to the                 | cause(s) a         | and manner as                                    | stated.  |
|          | the H<br>nin 24<br>the Fi   | ledical          | one)  |                                     | and manner sta                                  | ited.                       |  |                               |                                | d at the time,                |                    |  |  |
|          | Viti Viti   | Σ                | 29b Signature and   | d title of sertifier                | (01   | 1                           | 3 29c. LI                                  | cense numbe                   | 7 ~ C                          | 4                             | 29d. Date          | signed (Month                                    | n, Day, Year)                                      |
|          |   |                  | 20 Name and ada   | trock of necessary with             | completed sauce of di                           | oth (tow 222)               | Typo Brint\                                | 1006                          | 118                            |                               | 0 -                | -1-6   | //   |
|          | 6   |                  | Danie aga ado   | Cust !!                             | completed cause of de                           | 1 , /1                      | Ju. Pu 1                                   | 30×17                         | 733                            | Sali                          | sh                 | M  | 21802  |
|          | Sta   | te               | 31. Date filed (Mo.   | Mana di a                           |   | ar's Signature              | ,  |                               |                                |                               |                    | , ,  |  |
|          | Registr   | ar               |   | AUG 1 4                             | 2007 8084                                       | 48 0 18                     | Comelis                                    |                               |                                |                               |                    |  |  |

been signed by the attending physician and should be detached for use as the burial-trar Division or Vital Records, P.O. Box 68760. After this

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Day Year 0, MINIM 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Johns Hopkins Bryview Medical Center N/A Baltimore 5. Social Security Number Birthplace (State or Foreign Country) Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1□M 2**X**F Hours 67 212-36-3471 October 5, 1939 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 XYes 2 No NIA Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3222 Pelham Avenue 21213 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify 3 ₩idowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) city of Baltimore Office Assistant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Warczynski Helen A. Marcinko 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICK Warczynski / Brother 9102 Naygall Rd. Parkville 21234 MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Anatomy Gifts Registry August 13,2007 Hanover, MD 4 ■Donation 5 □ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature Funeral Service Licensee 1522 Connelley Drive Suite P. Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Jastroins /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perforn the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 [Pcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier ( 29c. License number 29d. Date signed (Month, Day, Year) Avgust 10,2007 Medical Dochor rson who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue Boltmore, MD Doctor Nicole 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|            |   |                |   | ertificate of   |  | Re   | eg. No.2007                                     | 26045  |
|------------|---|----------------|---|---|--|--|---|--|
|            | Physici<br>/Medic   |                | 1. Decedent's Name (First, Middle, Last) Florence Mary Kish   |   |  | 2. Date of Deat<br>Month<br>August           | Day 2007  | 3. Time of Death 11:40 A M                         |
|            | Examir  |                | 4a. Facility Name (If not institution, give street and number) Prince Georges Hospital Center   | Cheverly  |  |  | 4c. County of Dea                               | eorges   |
| l          | Funerai<br>Director   |                | 5. Social Security Number  060-01-3455    Galaxy   Security Number   6. Sex   7. Age (In yrs. last birthda, 1 or 1 o  | y) If Under 1 Year<br>Months Days   | Hours Min.   | 8. Date of Birth (Month, Day, MAR 7,         |   | thplace (State or Foreign<br>ountry)<br>W York     |
|            | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>he Medical Examiner must be notified at  | Director       | MD Prince Georges Laurel  |   |  |  |   | 10d. Inside City Limits 1 ☐Yes 2 XNo               |
|            | ath with t<br>23a or 3<br>ust be n  | ral Dir        | 7700 Cherry Lane, Apt 316   | 10f. Zip Code 20707   |  |  | 0g. Citizen of What Co<br>JSA                   | ountry?  |
| 036        | be filed within 72 hours after death with the Marylar ital Hygiene.<br>ed other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notified at   | by Funeral     | 11. Marital Status  1 ☐ Never Married 2 ☐ Married  1 ☐ Never Married 4 ☐ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes, Qive Year or Dates:  | 3. Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2 ☑ No                 | tispanic Origin? (Spe<br>an, Mexican, Puerto<br>Specify: | cify Yes or No-<br>Rican, etc.)              | 14. Race - Ame<br>Black, Whi<br>Specify:<br>Wh: | e, etc.  |
| 21215-0036 | within 72 ho<br>iene.<br>• than "natu<br>the Medical  | Completed      | (Specify only highest grade completed) (Gin   | sedent's Usual Occup<br>ve kind of work done<br>. DO NOT use retire<br>emaker | oation<br>during most of worki<br>d)                     | ng   | 16b. Kind of Business Own Home                  |  |
| 0          | 12 should be filed within n and Mental Hygiene. 7 is marked other than "traumatic event, the Mec  | Be             | 17. Father's Name (First, Middle, Last)   | III. III. III. III. III. III. III. III  | 18. Mother's Name  | (First, Middle, N                            | Maiden Surname)                                 |  |
| IL YIE     | should<br>nd Mer<br>marke<br>ımatic   | 2              | George William Pollock  19a. Informant's Name/Relationship (Type. Print)  19b. Ma   | iling Address (Street   |  |  | Burmester City or Town, State,                  | Zip Code)  |
| e, Ma      | and 2<br>ealth a<br>n 27 is<br>her trau   |                | Robert C. Kish/Son 1426   | 7 Oxford  | Drive Lau  | rel, MD                                      | 20707   |  |
| baltimore  | permit. Pages 1 and 2 should be<br>Department of Health and Menta<br>Important: If item 27 is marked<br>any Injury or other traumatic ev<br>once.   |                | I I Duliai 2 12 Lettation 3 Linemoval Ironi State 1   | position (Name of<br>rematory or other place<br>rematory,                     | Inc 8/11/  |  | 20c. Location - City or<br>Baltimore,           | ,  |
| Dall       | permit. Depart Import any Inj once,   |                | 21. Signature of Funeral Service Licensee C. Todd Dring   | 22. Name and Addre<br>Cremation<br>299 Frede                                  | ss of Facility<br>Society (<br>rick Rd Ba                | of Maryl                                     | and, Inc.<br>. MD 21228                         | 1  |
|            | Physician<br>/Medical   |                | 23a. Part1. Enter the disease, or omplication is that caused the death. Do not e shock, or heart failure. List only one of use on each line.  Immediate Cause (Final disease or condition resulting in death)  Augustic Massive hemorrha a.  Due to (or as a consequence of): | nter the mode of dyir   | ng, such as cardiac c                                    | r respiratory arre                           | est,  | Approximate<br>Interval Between<br>Onset and Death |
|            | Examiner<br>on the state of the st | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | lignant)  |  |  |   | years  |
| , 00/00    | tificate be executed<br>g physician and<br>as the burial-transit  | edical Exar    | that initiated events resulting in death) Last  C   |   |  |  |   |  |
| O. DOX 0   | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  | Physician/Med  |   | B □Ectopic pregnanc: □ Other (specify) □                                      | у  |  | 23d. Date of de<br>Month                        | livery<br>Day Year                                 |
| ecords, r  | equires that<br>en signed by<br>ould be deta  | þ              | Part II. Other significant conditions contributing to death but not resulting in the  | underlying cause giv  | ren in Part I.   | 23e. Did tob                                 | es 2X No 3 ☐ P                                  | o the cause of death?                              |
| אוומו חפכי | n: The law r<br>ficate has be<br>r, page 2 sh   | Completed      |   |   |  | 24a. Was ar<br>autops<br>perforn<br>1∐ Yes 2 | y prior to<br>ned? death?<br>X No 1 ☐ Yes       | utopsy findings available completion of cause of   |
|            | nysicia<br>nis certi<br>directo   | To Be          | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient   | ent 3 DOA Oth   | 26. Place of Death<br>ler: 4 ☐ Nursing Hor               |  | e)<br>nce 6                                     | cify)  |
| VISIOII O  | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification the Funeral Director. After the Funeral director, sompletely filled in by the funeral director,  | Certification: | 27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be   | M 1□  | ryat<br>k?<br>Yes 2 □ No                                 | 28d. Describe ho                             | w injury occurred                               |  |
| 2          | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: /<br>completely filled in by the fr  |                | 4 ☐ Homicide determined   20e. Place of Injury - At notine, farm, s building, etc. (Specify)  |   | ļ  | City or Town                                 |   |  |
|            | he Hosp<br>in 24 hou<br>he Fune<br>pletely fi   | Medical        | 29a. Certifier (Check only one)  1 X Certifying Physician: To the best of my knowledge, dea (Check only one)  Medical Examiner: On the basis of examination and/or and manner stated.   | ath occurred at the til<br>investigation, in my o                             | me, date and place, a<br>opinion, death occurr           | and due to the ca<br>ed at the time, da      | ause(s) and manner a<br>ate and place, and du   | s stated.<br>e to the cause(s)                     |
|            | To t<br>To t  | N              | 29b. Signature and title of certifier   | 29c. Licens   | 2865   |  | 9d. Date signed (Mon                            |  |
|            | ls.   |                | 30. Name and address of person who completed cause of death (Item 23a) (Type DR K. MICHKEL FIGARO 3001  | Print)  |  | Annale                                       | EDIJ MA   | 8, 2001<br>20185                                   |
| 16         | Sta<br>Registr  |                | DR K. MICHKEL FIGERO 3001 - 31. Date filed (Month, Day, Year) 4 2007 AUG 1 4 2007   | Sparles   |  | CHEVE  | nLI, MID  | 40/00  |

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                         |  |                | 1 - For<br>State<br>Registrar  | State of Ma                                     | aryland /                |                       | artment of F<br><i>rtificate of</i>     |                                   | nd Me                 |   | giene<br>Reg. No | C U U 1                    | 6                                     | 26046  |
|-------------------------|--|----------------|--|---|--------------------------|-----------------------|---|-----------------------------------|-----------------------|---|------------------|----------------------------|---------------------------------------|--|
|                         | Di   |                | 1. Decedent's Name (First, Middle, La  | ast)  |                          |                       |   |                                   | 1                     | 2. Date of Dea<br>Month                   | ath              |                            |                                       | 3. Time of Death                               |
|                         | Physic<br>/Medi  |                | Donald Kolodn  | е   |                          |                       |   |                                   |                       | Augus                                     | Da<br>t (        | Year 200                   |                                       | 2:20 p <sup>M</sup>                            |
|                         | Exami  | ner            | 4a. Facility Name (If not institution of Manor Ca  | ve street and number).<br>Te Bethesd            | а                        |                       | 4b. City, Town, o                       | or Location of I                  | Death                 |   | 40               | . County of De             | ath                                   |  |
|                         |  | 10             | 6530 Democracy   | Boulevard                                       |                          |                       | Bethe                                   |                                   | 4 1 1                 |   |                  | Mont                       |                                       |  |
|                         | Funeral<br>Director  |                | ,  | Sex 7. Ag<br>1 🔯 M 2 🗆 F                        | e (In yrs. last b<br>Ω 1 | Yrs.                  | If Under 1 Year<br>Months Days          |                                   | Min.                  | B. Date of Birtl<br>(Month, Day<br>May 8, | y, Year          | 9. B                       | inthplac<br>Co <i>u</i> n <i>try,</i> | e (State or Foreign                            |
|                         |  |                | Usual Residence of Decedent  |   | 01                       |                       |   |                                   |                       | may o,                                    | 192              | zo wa                      | snıı                                  | ngton, DC                                      |
|                         | yland  |                | 10a. State 10b. County   |   | 10c. City, To            | wn or Lo              | cation                                  |                                   |                       |   |                  |                            | 10d.                                  | Inside City Limits                             |
|                         | death with the Maryland<br>ma 23a or 28a-f ahow<br>f must be colified at   | Director       | Maryland Montgo  | omery   | Beth                     | esda                  |   |                                   |                       |   |                  |                            |                                       | 1 X Yes 2 ☐ No                                 |
|                         | 라 다<br>or 28   | - Se           | 10e. Street and Number   |   |                          |                       | 10f. Zip Code                           |                                   |                       |   | 10g. Ci          | tizen of What C            | Country                               | ?  |
|                         | ath w  |                | 6530 Democracy E   | Soulevard                                       |                          |                       | 2081                                    | 17                                |                       |   | U                | nited S                    | Stat                                  | es   |
|                         | er de  | Funerai        | 11. Marital Status   | 12. Was Decedent<br>Armed Forces?               |                          | 13.                   | Vas Decedent of H<br>Yes, specify Cuba  | Hispanic Origin<br>an, Mexican, F | n? (Spec<br>Puerto Ri | ify Yes or No-<br>ican, etc.)             |                  | 14. Race - Am<br>Black, Wh | nerican<br>lite, etc.                 | fndian,  |
| 36                      | rs aft   | by F           | 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced   | 1 ⊠ Yes 2 ☐ f<br>If Yes, Give<br>Year or Dates: | v₀<br>WWII               |                       | ☐ Yes 21x No                            | Specify:                          |                       |   |                  | Specify:                   |                                       |  |
| 号                       | within 72 hours after<br>ene.<br>than "natural", or ite  | ed             | 15. Decedent's E   |   |                          | Dece                  | lent's Usual Occup                      | ation                             |                       |   | 16b K            | Wind of Busines            | nite                                  |  |
| 212                     | nin 72   | Completed      | (Specify only highest gr   | ade completed)                                  |                          | (Give                 | kind of work done of NOT use retired    | during most of                    | of working            | 7   | 100.11           | and of Dasinos             | 211003                                | uy   |
| 2                       | d with   | ĕ              | Ciententary/Secondary (0-12)   | College (1-4or 5<br>4                           | 1+1                      | Ci                    | vil Engir                               | neer                              |                       |   |                  | Contrac                    | ctor                                  | •  |
| 2                       | should be filed within 72 hours after death with the Marylan of Mental Hygiene.<br>marked other than "natural", or Itema 23a or 28e-1 ahow imatic event, its Medical Examinar must be collified as     | Bec            | 17. Father's Name (First, Middle, Last   | ')  |                          |                       |   | r                                 | s Name (              | First, Middle,                            | Maiden           | Sumame)                    |                                       |  |
| <u>ā</u>                | should be<br>ind Mental<br>marked o  | 2              | Abraham Kolodne  |   |                          |                       |   | Jean                              | nette                 | e Weit                                    | zma              | n                          |                                       |  |
| Maryland 21215-0036     | 0 0 0  |                | 19a. Informant's Name/Relationship   |   | 19                       | b. Mailir             | g Address (Street                       | and Number                        | or Rural I            | Route Numbe                               | r, City          | or Town, State,            | Zip Co                                | ode)   |
|                         | 1 and 2<br>Health<br>tem 27  | 1              | Shirley B. Katz  | / Sister  |                          |                       | Galvez S                                |                                   |                       |   | $\mathbb{D}$ 2   | 0906                       |                                       |  |
| 0                       | Pages 1<br>nent of H<br>int; If Iter   | 11             | 20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 3 ☐   | Removal from State                              | 20b. Place cemete        | of Dispo<br>ery, cren | sition (Name of<br>natory or other plac | сө)                               | Dat                   | te  | 20c. L           | ocation - City o           | r Town,                               | , State  |
|                         | tmen<br>tant:  |                | 4 Donation 5 Other (Speci  | fy)   | Ft. Li                   |                       | ln Cremat                               |                                   | 3/9/2                 | 2007                                      | Bre              | ntwood                     | , Ма                                  | ry1and   |
| Baltimore,              | permit. Pages<br>Department of I<br>Important: If It<br>any injury or o  |                | 21. Signature of Funeral Service Lice  | nsee  |                          |                       | Name and Addre                          |                                   |                       | nple Tr                                   |                  |                            |                                       |  |
|                         | 40140  |                | 220 Post (Forum of some of   | - Banking About                                 | Ab - HAb - Do            |                       | 040 Rocky                               |                                   |                       |   |                  | e, Mary                    |                                       |  |
|                         |  |                | 23a. Part 1 Enter the disease, of don<br>shock or heart failure. List only                       | one cause on each lin                           | ine death. Do            | not enti              | er the mode of dyin                     | ng, such as ca                    | irdiac or i           | respiratory arr                           | rest,            |                            | Int                                   | pproximate<br>tervaf Between<br>nset and Death |
|                         | hysician //Medical   |                | Immediate Cause (Final disease or condition resulting in death)                                  | a Sepsis  |                          |                       |   |                                   |                       |   |                  |                            |                                       | weeks  |
|                         | Examiner   |                | 1  |   | a consequence            | of):                  |   |                                   |                       |   |                  |                            |                                       |  |
|                         |  | er             | Sequentially list conditions,  | b. Pneumon                                      | 1a<br>s consequence      | of):                  |   |                                   |                       |   |                  |                            | 3                                     | weeks  |
| ,                       | uted<br>d<br>ansit   | Examiner       | any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Multip1   |                          |                       |   |                                   |                       |   |                  |                            | 3                                     | weeks  |
| <u> </u>                | execting and in and inal-tra   | Exa            | resulting in death) Last   | •   | a consequence            |                       |   |                                   |                       |   |                  |                            |                                       | WEEKS  |
| <b>δ</b> 8/ <b>δ</b> 0, | ificate be executed<br>g physician and<br>as the burial-transit  | edicai         |  | d. =  |                          |                       |   |                                   |                       |   |                  |                            |                                       |  |
|                         | = co a   | Medi           | 15.55  |   |                          |                       |   |                                   |                       |   |                  |                            |                                       |  |
| X<br>D                  | The law requires that the death certif<br>ate has been signed by the attending<br>page 2 should be detached for use a  | by Physician/M | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome 1 ☐ Live birth             |                          | 3.                    | Ectopic pregnancy                       | ,                                 |                       |   |                  | 23d. Date of de            | elivery                               |  |
|                         | e dea<br>he at   | sici           | in the past 12 months?<br>1 ☐ Yes 2 🛣 No   | 4☐ Pregnant at<br>9☐ Unknown                    |                          |                       | Other (specify)                         |                                   |                       |   |                  | Month                      | Da                                    | y Year   |
|                         | d by t   | Phy            | 9 Unknown  |   |                          |                       |   |                                   |                       |   |                  |                            |                                       |  |
| Ś                       | res th   | þ              | Parkinsons Dise  |   | it not resulting         | in the ur             | derlying cause give                     | en in Part I.                     |                       |   |                  | use contribute t           |                                       |  |
| cords,                  | need   | Completed      |  |   |                          |                       |   |                                   | -                     | 1   Y                                     | es 2             | UN0 3UF                    | robably                               | y 4 ⊠Unknown                                   |
| ၌                       | e law<br>has t   | ig III         | Failure to thri  | ve  |                          |                       |   |                                   |                       | 24a. Was a autops                         | SV               | prior to                   | comple                                | findings available etion of cause of           |
|                         | r: Th  |                |  |   |                          |                       |   |                                   |                       | performula 1 Yes                          |                  | death?<br>1 ☐ Ye           |                                       | ] No   |
| =                       | certif   | Be             | 25. Was case referred to medical examiner?   | Hospital:                                       |                          |                       | 2□ DOA Othe                             |                                   |                       | Check only on                             |                  |                            |                                       |  |
| 5                       | Phy<br>r this  | . To           | 1 ☐ Yes 2 ☑ No  27. Manner of Death  | 1 ☐ Inpatie                                     |                          | utpatient             | 3 DON                                   | 4123 IAMI21                       |                       | d. Describe ho                            |                  | 6 □Other (Spe              | ecify)                                |  |
| INISION                 | ding<br>th.<br>Afte  | tion           | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation  | (Month, Day                                     |                          | Injury                | 28c. Injury<br>Work                     | k?<br>Yes 2∐No                    |                       | u. 20001100 III                           | ove anjun        | y cocarrou                 |                                       |  |
| 2                       | Atter<br>r dea<br>ector<br>by the  | Hica           | 3 Suicide 6 Could not b  | e 28e. Pface of fnits                           | ry - At home, fa         | arm, stre             |   |                                   |                       |   |                  | d Number or F              | Rural Ro                              | oute Number,                                   |
| 5                       | s after  | Certification: | 4   Homicide   | building, etc                                   | . (Specity)              |                       |   |                                   |                       | City or Town                              | n, State         | 9)                         |                                       |  |
|                         | To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. within 44 hours after death. completely filled in by the funeral director, page 2 should be detached |                | 29a. Certifier 1 Certifying Ph   | ysician: To the best of                         | f my knowledg            | e, death              | occurred at the tim                     | ne, date and p                    | olace, and            | d due to the c                            | ause(s)          | and manner a               | s state                               | d.   |
|                         | the H<br>in 24<br>the F<br>iplete  | Medicai        |  | niner: On the basis of<br>and manner sta        | examination ar           | 10/or inv             | estigation, in my op                    | pinion, death o                   | occurred              |   |                  |                            |                                       |  |
|                         | 5 til 5 til  | 2              | 29b. Signature and title of certifier  | 12  |                          |                       | 29c. License                            | e number                          | 0                     | 2   | 9d. Dat          | te signed (Mon             | Day                                   | (, Year)                                       |
|                         |  |                | - Munul  | 1 (1  | NI,                      |                       | 01                                      | 160                               | 1                     |   | H                | 19 6                       | 2                                     | ab 1.  |
|                         | 10   |                | 30. Name and address of person who Ramani R. Tuli, M   | completed cause of de                           | ath (Item 23a)           | (Type, I              | oad Ste-                                | 202.                              | Gait                  | hersbu                                    | rg.              | Marv1a                     | nd                                    | 20878  |
|                         | Sta  | 10             | 31. Date filed (Month, Day, Year)  | 20 Pagistro                                     | do Cionatura             |                       |   | , \                               |                       |   |                  |                            |                                       |  |
|                         | Registr  |                | AUG 1 4 200  | 17 Maria  | S Signature              | 1270                  |   |                                   |                       |   |                  |                            |                                       |  |
|                         |  |                | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | 2   |                          | 3/                    |   |                                   |                       |   |                  |                            |                                       |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day **Physician** 2007 /Medical Anthony John August 11 4:07 Kewer 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 4425 Norfen Road
5. Social Security Number 6. N/A
If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F 216-04-8507 24 Director June 6, 1983 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Baltimore Baltimore Highlands 1 □Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4425 Norfen Road 21227 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 2001 2004 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Crew Chief National Guard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental h pe Richard L. Kewer, Jr. Helen Ridgely 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Shannon Kewer/Wife 96 Old Jenkins Road Milford, DE 19963 Department of Health Important: If item 27 any injury or other tr. once. 20b. Place of Disposition (Name of 20c. Location - City or Town, State Meadowridge Memorial Park Pages 1 4. □Donation 5 □ Other (Specify) 8-14-2007 Elkridge, Maryland 21. Annature of Funeral Service Licensee Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Rd. Lansdowne MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Suicide Asishyx19 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Out to for as a consequence off Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has 1 Yes 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2□ No P this in by the funeral 28d. Describe how injury occurred Suicide By Hanging 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? After Attending 1 Natural 5 Pending investigation Hospital or At., hours after death.

I Director: A<sup>r</sup>
by the Au(wstir zco7 | 0407 A M | 1 = 28e. Tace of injury - At home, farm, street, factory, office building, etc. (Specify) 1 🗌 Yes 2 Accident 3 Suicide 4 ☐ Homicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 44254474649E To the Hospital o within 24 hours aft To the Funeral Di completely filled in NORFENROAD Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Millitello Trimble HillC+. Lutherville mi) 6 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Yea AUG 1 4

Year) 4 2007

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month JOHN KENNETH KASKO August 10, 2007 4:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1101 Saint Paul Street, #1001 Baltimore N/A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F 68 Director Jan 1, 1939 213-36-9995 Washington, DC Usual Residence of Decedent the Maryland 10a. State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits 28e-f show Examiner must be notified at Director N/A 1X Yes 2 ☐ No Macyland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 1101 Saint Paul Street, #1001 Items 23a 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) 1 yc Elementary/Secondary (0-12) Computer Programer State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental ? John Joseph Hooks Catherine Josephine Ritzmann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 other tra Toni Hooks Kasko (Wife) 1101 Saint Paul St., #1001, Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ita any injury or ot once. 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Green Mount Crematory 8/14/2007 Baltimore, Maryland 21. Signatur Francia Service Dicember e Martin D. Lawson MATCHECL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Penitoneal **Physician** Cancinomatosis womenths /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Unicertying Cause (Disease or injury Due to (or as a consequence of): Examine burial-transit or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural
2 Accident To the Hospital or reserved within 24 hours after death.

To the Funaral Director: After the funaral on by the fur 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 007 Charles St OWSON, Manyland 21204 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

State

Registrar

1838

M.D.

32. Registrar's Signature

RICHARDSON

AUG 1

31. Date filed (Month, Day, Year)

GREENE TREE RUAD # 300

1KESVILLE

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death **Physician** NANE 4:20 M UGUST 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ALTIMORE JOHNS HOPKINS HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Pay, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1□M 2**X**F 217-68 -0886 MARY/AND Director HAUST 02 1958 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 XYes 2 □ No NA BAHIMORE Directo MARY land 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ms 23a or USA 21213 Funeral ortant: If Item 27 is marked other than "natural", or items. Injury or other traumatic event, the Medical Examiner mu Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No δ AMERICAL 3 Widowed 4 Divorced Africas Ame Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omestic WORKER 124h OWN permit. Pages 1 and 2 should be file Department of Health and Mental Hv. Important: If Item 27 Is many Injury over 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Earline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Street - BAHIMETE, MAKE Sloria 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Ø Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) DINGELK, MARYLAND August 17, 2017 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Nancy m. Walling Funesse Kuny 3405 W. FRANKLIN Street BAHIMORE, MARYLAND 31339 Cenecare Approximate Interval Between Onset and Death 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearth illure. List only one cause on each line. Immediate Cause (Final Immediate Cause (Final disease or condition resulting in death) **Physician** reas /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to finh educate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for es a consequence of: Examiner burial-tran Due to (or as a consequence of) Physiclan/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 200 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be

Division or Vital Records, P.O. Box 68760, within 24 hours a To the Funeral I

Baltimore, Maryland 21215-0036

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mach Medical Doctor

29c. License number RES-000 29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (item 23a) (Type, Print)

THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE ST., BALTIMORE MARYLAND ZILES ASON MOCK 31. Date filed (Month, Day, Year) AUG 1 4 2007

State Registrar

Medical

07-05884 Esia Lopez Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

|   |                | For State   | •                      |   | Certifica                | ate of         | Death                        |                |                     |                |                                     | Reg. No.          |                    |                     |  |           |
|---|----------------|---|------------------------|---|--------------------------|----------------|------------------------------|----------------|---------------------|----------------|-------------------------------------|-------------------|--------------------|---------------------|--|-----------|
| Physicia  | n/ 1           | Decedent's Name (First, Midd  | _                      |   |                          |                |                              |                |                     |                | . Date of Dea<br>Month<br>August 1. | Day               | Year               |                     | 3. Time of Death<br>1043 hrs                     |           |
| Examin  |                | Esai Angel  a. Facility Name (if not institution  |                        |   |                          | 4              | b. City, Tow                 | n, or Lo       | cation of           |                | 7.togoot 1                          |                   | c. County o        | f Death             |  |           |
|   |                | University Hospital   | on, give on our ame    | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                          |                | Baltimo                      |                |                     |                |                                     |                   | Balt               |                     |  |           |
| Funeral   | 5              | . Social Security Number  | 6. Sex                 | 7. Age (I                               | n yrs. last birt         | hday)          |                              |                | If Under<br>Hours   | 24Hrs.<br>Min. | 1                                   |                   |                    | 9. Birth<br>Foreign | place (State or<br>New Jet                       | rsey      |
| Director  | _              | 154-88-6786<br>145-886786   | 1 X M 2                | F                                       | 1                        | L7 Yrs.        | Months                       | Days           | nouis               | WIIII.         | 04/13                               | /19               | 90                 | Cour                | ntry)  |           |
|   | (1 a)          | Isual Residence of Decedent   |                        |   | c. City, Town            |                |                              |                |                     |                |                                     | <del></del>       | ·                  |                     | 10d. Inside City L                               | Limits    |
| v any   | 1              | 0a. State 10b. County   | /                      | [10                                     |                          |                |                              |                |                     |                |                                     |                   |                    |                     | 1 x Yes 2  | No        |
| land<br>f sho   | اق             |   | ntgomery               |   | Gaithe                   | ersbu          | 1rg<br>10f. Zip C            | ode            |                     |                |                                     | 10g. Ci           | itizen of Wh       | at Count            | ry?  |           |
| Mary<br>r 28a-<br>ed at   | Director       | 0e. Street and Number   | . Cabaal               | Pood                                    | #4424                    |                | 208                          |                |                     |                |                                     | U                 | nited              | Sta                 | ites   |           |
| with the Maryland<br>ms 23a or 28a-f show<br>be notified at once.   |                | 8519 Snouffer   |                        | Decedent Ev                             |                          | 13. Wa         | s Decedent                   | of Hisp        | anic Origi          | n? (Spe        | ecify Yes or N                      | lo-               |                    |                     | an Indian, Black,                                | ,         |
| ath wi  | - T            |   | Married Arme           | d Forces?                               | No                       | If Y           | es, specify                  | Cuban,         | Mexican,            | Puerto F       | Rican, etc.)                        |                   | White              | e, etc.             |  |           |
| ter de ", or er mu  |                | 3 Widowed 4 D   | 1 Yes                  |   |                          |                |                              |                |                     |                | to Ric                              | an                | Specify:           |                     |  | 41.00     |
| b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fault hand Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once   | d b            | 15. Decedent's Education (Sp  | ecify only highest     | grade compl                             | leted) 16a.              | Deceden        | it's Usual O<br>ost of worki | ccupation      | on (Give k          | ind of wo      | ork done                            | 166               | Kind of Bu         | usiness/ir          | idustry  |           |
| 72 hc   | leted          | Elementary/Secondary (0-12  | 2) Colleg              | je (1-4 or 5+                           | )                        |                | . Fa                         | ast            | food                |                |                                     |                   | lucati             | ion /               | Servic   | e         |
| vithin ene.   | Comple         | 11  | (a. ) a = 1)           |   | St                       | uaen           | t / Te                       | eam<br>Ti      | Memb<br>8.Mother's  | er<br>s Name   | (First, Middle                      |                   |                    |                     | DCIVIC   |           |
| 15-C  |                | 17. Father's Name (First, Midd<br>Jose Antonio<br>Antonio Jose                                    | Lopez Sr               | •                                       |                          |                |                              | 1              |                     |                | lenee                               |                   |                    |                     |  |           |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica  | To Be          | 19a. Informant's Name/Relation  | nship (Type, Print     | )                                       | 19                       | b. Mailin      | g Address                    | (Street        | and Num             | ber or R       | ural Route N                        | lumber,           | City or Tov        | vn, State,          | Zip Code) 20                                     | 879       |
| MD d 2 shoulth and in 27 is aumatic   |                | Leslie R. Lo  | pez                    |   |                          |                |                              |                |                     | o1 F           |                                     | 4424              | , Ga               | ithe                | rsburg,<br>Town, State                           | MD        |
| e, Nand Health  |                | 20a. Method of Disposition  |                        | al from State                           | 20b. Place<br>crema      | of Dispos      | sition (Name<br>ther place)  | e of cem       | netery,             |                | Date                                |                   |                    |                     |  |           |
| nor<br>Pages<br>ent of<br>nt: If  | Ш              | 1 X Burial 2 Cremati 4 Donation 5 Other   |                        | al Ironi Stati                          | Frank                    | lin :          | Memor                        | ial            | Park                | 8/1            | 10/200                              | 7 1               | N. Br              | unsw:               | ick, NJ  |           |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natura injury or other traumatic eyent, the Medical Examin  | ı              | 21. Signature of F and Servi  | ce Licensee            |   |                          |                | Name and A                   |                |                     |                | nple T                              | rib               | ute                |                     |  |           |
| ii ii De 📆  | 1              | 11-2.0  | A                      |   |                          | 10             | 40 Ro                        | ckv            | ille                | Pike           | Roc                                 | kvi.              | lle, I             | Mary<br>eart        | 1 and 208  | Interval  |
| Physician   |                | 23a. Part. Exter the disease filure. Lirt only one call   | se on each line.       |   | ne death. Do r           | not enter      | the mode of                  | uying,         | 3001 03 0           | ardido o       | , 100pa.c.,                         |                   |                    |                     | Between Ons<br>Death                             |           |
| Aedical<br>_xaminer   | - 1            | Immediate Cause (Final diseasor condition resulting in death                                      | Multiple               | Injuries<br>as a consec                 | quence of):              |                |                              | -              |                     |                |                                     |                   |                    |                     |  |           |
|   |                |   | b.                     | as a consci                             | quenos ory.              |                |                              |                |                     |                |                                     |                   |                    |                     | ļ  |           |
|   | ē              | Sequentially list conditions, if any, leading to immediate  |                        | as a conse                              | quence of):              |                |                              |                |                     |                |                                     |                   |                    |                     |  |           |
| 1   | Examiner       | cause. Enter Underlying Cau<br>(Disease or injury that initiate<br>events resulting in death) Las | d C. Due to /or        | as a conse                              | quence of):              |                |                              |                |                     |                |                                     |                   |                    |                     |  |           |
| recuted and ransit  |                | events resulting in deathy La.  | d                      |   |                          |                |                              |                |                     |                |                                     |                   |                    |                     | <del>                                     </del> |           |
| e exec<br>cian at<br>rial - t   | Medical        | UNPENDED  | X AMENI                | DED #5.                                 | 17.per                   | ғн. <b>с</b> 8 | 71.9/10                      | 0/07.          | WS                  |                |                                     |                   |                    |                     |  |           |
| 760,<br>cate be exec<br>physician a   |                | IF FEMALE:<br>23b. Was decedent pregnant i  |                        | yes, outcom<br>Live birth               | e of pregnanc            | CV.            | etal death                   | •              |                     | c pregna       | ancy                                |                   | 23d. Date<br>Month |                     | •  | ear       |
| Sox 687<br>leath certific<br>e attending<br>for use as t  | sician         | past 12 months?   |                        |   | time of death            |                | Other (Spec                  |                |                     |                |                                     |                   |                    |                     |  |           |
| Box 687 e death certific the attending ed for use as t  | ıysi           |   |                        | Unknown                                 |                          |                |                              |                |                     |                | 220 5                               | id tobo           | 200 1100 001       | atribute tr         | the cause of de                                  | eath?     |
| D.O. I<br>that the<br>ned by ti   | y Phy          | Part II. Other significant cor  | nditions contribu      | ting to death                           | but not result           | ting in the    | underlying                   | cause          | given in P          | art I.         |                                     |                   |                    |                     | bably 4 Un                                       |           |
| s, P.   | d by           |   |                        |   |                          |                |                              |                |                     |                |                                     | Vas an            |                    | . Were a            | utopsy findings a                                | available |
| ords w request speem  | olet(          |   |                        |   |                          |                |                              |                |                     |                | а                                   | utopsy            |                    | prior to death?     | completion of ca                                 | ause of   |
| Che lav   | Completed      | 4   |                        |   |                          |                |                              |                |                     |                | 1 🗸 Y                               | es 2              |                    | 1 🗸                 | res 2  | No        |
| Division of Vital Records, P.O tal or Attending Physician: The law requires that t is after death.  "al Director: After this certificate has been signed by in high the funeral director, page 2 should be detected.  | Be C           | 25. Was case referred to med examiner?  | dical<br>Hospital:     |   |                          |                |                              | 71111          | e of Death<br>Other | 0.             | only one)<br>ing Home 5             | Re                | esidence (         | Oth                 | er:  |           |
| Vit<br>hysic<br>rthis   | 10             | 1 ✓ Yes 2 No  |                        | Date of Inju                            | ent 2 🗸 ER               | b. Time o      |                              | OA<br>28c. Ini | ury at Wo           |                | 28d. Desc                           | ribe ho           | w injury occ       | urred               |  |           |
| J Of<br>Ling P<br>After<br>funer  | Ë              | 27. Manner of Death  1 Natural 5  | Pending Jul            | Month, Day Y<br>31, 2007                |                          | 000 hrs        | ,,                           |                | Yes 2 ₩             | _              | Pedestri                            | an str            | ruck by v          | ehicle              |  |           |
| IVISIOF or Attend after death Director:   | cati           | 2 🗸 Accident  | Investigation 286      | Place of In                             | njury - At home          | e, farm, st    | reet, factory                | , office       | building,           | etc.           | 28f. Locat                          | ion (Str          | eet and Nu         | mber or F           | Rural Route Num                                  | ber, Cit  |
| Divi<br>al or<br>al Dir<br>ed in  | Certification: |   | Could not be           |   | jor Road /               |                |                              |                |                     |                | Redland                             | wn, Sta<br>Road ( | @ Muncas           | ster Mill           | Road, Gaithers                                   | sburg,    |
| Lospit<br>4 hour<br>uner:   | ြင္ဆ           | 20a Certifier   | - T- 1                 | h = h = a4 a6 ma                        | ka awlodge               | death occ      | curred at the                | e time,        | date and p          | olace, ar      | nd due to the                       | cause(            | s) and man         | iner as st          | ated.  |           |
| Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Medical        | one) 2 Medical  | Examiner:On the and ma | basis of exa                            | mination and/            | or investig    | gation, in m                 | y opinic       | n, death o          | occurred       | at the time,                        | gate a            | iu piace, ai       | id due to           |  |           |
| F P S   | Me             | 29b. Signature and title of ce  |                        |   |                          |                | 29                           |                | nse numbe           | er             |                                     | ì                 |                    |                     | /lonth, Day,Year)<br>•                           |           |
|   |                | Calo  | Reus                   |   |                          |                |                              | 0.0            | .M.E.<br>           |                |                                     |                   | August :           |                     |  |           |
| 0   |                | 30. Name and address of pe  |                        |   |                          | 3a)            | nn Stree                     | t Balt         | imore               | MD 21          | 201                                 |                   |                    |                     |  |           |
| 7   |                | Laron Locke MD.   | Assistant M            |   | aminer<br>ar's Signature | - Pe           |                              | , pail         |                     | .,,,, _ 1      |                                     |                   |                    |                     |  |           |
| Regi  | State<br>stra  | 41111-1   | 4 2007                 | JE Negisti                              | a. J. Signature          | for.           | 2000                         |                |                     |                |                                     |                   |                    |                     |  |           |
| DHMH 17 Rev 1   |                |   | OCME                   | 4.70                                    | at                       | ORIGIN         | VAL                          |                |                     |                |                                     |                   |                    |                     |  |           |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Harold Litton 6:15 PM Aug. 9 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 901 N. Kresson Street Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**X** M 2 □ F April 12,1930 West Virginia 214-26-4674 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f shov Examiner must be notifled at 1 XYes 2 No Maryland N/A Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 901 N. Kresson Street 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 【No Specify. Specify: White þ 3 N Widowed 4 □ Divorced al Hygiene. I other than "natura event, the Medical E Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Anchor Motor Freight 6 years Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Vance Litton Zelpha Richardson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 901 N. Kresson Street, Baltimore, MD. 21205 Helen Wagoner Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages of Pepartment of Himportant: If Ite any Injury or of once. August 13, 1 Burial 2 □ Cremation 3 □ Removal from State Cardens of Faith Cemetery Rosedale, Maryland 4 ☐ Donation ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of rying, such as cardiac or r spiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or uence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine Division or Vital Records, P.O. Box  $68760 imes_{\mathcal{L}}$ g physician and as the burial-trans Due to (or as a consequence of) Physician/Medical anding p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy signed by the atter I be detached for u in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2₽No 3 Probably 4 Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performe page After this certificate 1 Yes 2 No funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 10 1 Yes 2 No 1 Inpatient 3□ DOA 4 Nursing Home 5 A Residence 6 □Other (Specify) 2 ER/Outpatient 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Matural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At hon building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) At home, farm, street, factory, office 4 ☐ Homicide

State

24 hours a

within 24 ho

To the Fun

completely

Dr. Kashi 31. Date filed (Month, Day, Year) 1 A

29a. Certifier

29b. Signature and title of ce

30. Name and address

Medical

3029 Dundalk Avenue, Dundalk, MD. 32. Registrar's Signature

and manner stated

of person who completed cause of death (nem-23a) (Type, Print)

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

21222

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 3, 2007 Physician Edwin C. Lanham 5:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 9008 Simpson Lane Clinton Date of Birth Month, Day, Y Jan 21, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 578 30 3962 Director Washington DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he maitted as 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Clinton 1 □Yes 2XXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20735 9008 Simpson Lane United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black. White, etc. 1. Yes 2 No It Xes, Give Vietnam Year or Dates: Vietnam 1 Never Married 2 Married 1 ☐ Yes 2√T√No Specify: 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Ret U.S. Army Military 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wei1 Frederick H.Lanham Emma ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9008 Simpson Lane. Clinton, MD 20735 19a. Informant's Name/Relationship (Type. Print) Edith M. Lanham (Wife) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug 21, Date 2007 20c. Location - City or Town, State Arlington National Cemetery 4 □ Donation 5 □ Other (Specify) Arlington, Virginia 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licens Alexandria Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Advanced **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Examine burial-tra Due to (or as a consequence of) physician a Physician/Medical as IF FEMALE for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ g 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who co (Item 23a) (Type, Print) ince Fredrick, MD 20678

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

nti, Day, Year) AUG 1 4

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 10:00 AM Steven Lehrer 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 1808 Upper Ford Lane Carroll <u>Hampstead</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 214-92-4017 37 Mary Tand April 12,1970 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carroll 1 □Yes 2 No Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1808 Upper Ford Lane 21074 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2X No Specify: White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 0wner Body Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Cryser Noraleen Lehrer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ms. Melinda Pace / Fiance 1808 Upper Ford Lane Hampstead. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 8/15/2007 4 ☐ Donation 5 ☐ Other (Specify) Towson, MD 21. Signature of Funeral Service Licensee Kimberty, Davidson 22. Name and Address of Facility 5305 Harford Rd. Baltimore, MD 21214 Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Obstructive step aprea Due to (or as a consequence of):

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hc. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur. any injury or other traumatic event, the Medical once.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f show adical Examiner must be notified at

Director

Funeral

ģ

Completed

Be

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-trans attending physician I for use as the buria signed by the a page 2 should

law requires that the death certificate be execute

Division or Vital Records, P.O. Box 68760

Examiner Physician/Medical Be Completed by Certification: To After t within 24 hours after death To the Funeral Director: completely filled in by the Medical

| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Morbid Due to (or as a consect Due to (or as a consect Due to (or as a consect d. My parte | n artery quence of):        | disease                             |                            |  |  |
|--|---|-----------------------------|-------------------------------------|----------------------------|--|--|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome pf pregn<br>1 Live birth 2 Feta<br>4 Pregnant at time of c               | al death 3 □Ectopie         | c pregnancy<br>(specify)            |                            | 23d. Date of d<br>Month                | lelivery<br>Day Year   |
| Part II. Other significant conditions of   | ontributing to death but not res  | sulting in the underlyin    | g cause given in Part I.            |                            | d tobacco use contribute               | to the cause of death?  Probably 4 □Unknown                              |
|  |   |                             |                                     |                            | topsy prior to<br>rformed death        | autopsy findings available<br>o completion of cause of<br>?<br>es 2 □ No |
| 25. Was case referred to medical examiner?   |   |                             |                                     | ath (Check only            | y one)                                 |  |
| 1 X Yes 2 No   | Hospital: 1 ☐ Inpatient 2 ☐   | ER/Outpatient 3□            | DOA Other: 4 Nursing                | Home 5 Re                  | sidence 6 Other (Sp                    | pecify)  |
| 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury      | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describ               | e how injury occurred                  |  |
| 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined   | 28e. Place of injury - At he<br>building, etc. (Special                                       | ome, farm, street, factify) | tory, office                        | 28f. Location<br>City or T | (Street and Number or I<br>own, State) | Rural Route Number,  |
|  | nysician: To the best of my known iner: On the basis of examination and manner stated.        |                             |                                     |                            |  |  |
| 29b. Signature and title of certifier  |   |                             | 29c. License number                 |                            | 29d. Date signed (Mo                   | nth, Day, Year)  |
| 1 / line   |   |                             | D006050                             | 3                          | 8/13                                   | 107  |

To the Hospital or Attending Physician:

31. Date filed (Month, Day, Year) State Registrar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Staritz, MD

2111 Hanover Pike

21074

Hampstead MP

|   |                | 1 - For<br>State<br>Registrar  | State of Maryla  |                                | rtificate of  |  | , ,                                     | . No. 200               | 7 26050  |
|---|----------------|--|--|--------------------------------|---|--|---|-------------------------|--|
| Physici   |                | Decedent's Name (First, Middl     MARVIN   | e, Last)<br>MARCUS   |                                | LACHM   | AN   | 2. Date of Death<br>Month<br>AUGUST     | Day Yea                 |  |
| /Medic<br>Examin  |                | 4a. Facility Name (If not institution Sinai Hospita  | n, give street and number)   |                                | 4b. City, Town, or  | Location of Death                              | 0.000                                   | 4c. County of De        | ath  |
| Funeral   |                | 5. Social Security Number  | 6. Sex 7. Age (In yr   | rs. last birthday)             | Bautimo If Under 1 Year Months Days                             | If Under 24 Hrs. Hours Min.                    | 8. Date of Birth                        | 9. B                    | A<br>irthplace (State or Foreign<br>Country)<br>MD |
| Director  |                | 219-07-9237 Usual Residence of Decedent  |  | 86 Yrs.                        |   |  | 11/14/19                                | 920                     | "MD  |
| death with the Maryland<br>ims 23a or 28a-f show<br>r must be notified at   | ō              | 10a. State 10b. County   | ALTIMORE 10c. C  | City, Town or Lo               | GS MILLS  |  |   |                         | 10d. Inside City Limits 1 ☐ Yes 2 🕅 No             |
| ith the lor 28a-  | Director       | 10e. Street and Number   |  | ONTIN                          | 10f. Zip Code   |  | 10g                                     | . Citizen of What (     | Country?   |
| death w<br>ms 23a<br>must b   | Funeral        | 3 MELISSA COU  | 12. Was Decedent Ever in   | U.S. 13. V                     |   | 1117<br>ispanic Origin? (Span, Mexican, Puerto | ecify Yes or No-                        | 14. Race - An           | Anerican Indian,                                   |
| filed within 72 hours affer of<br>Hygiene.<br>ther than "natural", or iter<br>int, the Medi–al Examiner   | by             | 1 ☐ Never Married 2 🛣 Marri<br>3 ☐ Widowed 4 ☐ Divorced  | Armed Forces?  1 X Yes 2 □ No If Yes, Give Year or Dates:                              |                                | lf Yes, specify Cuba<br>1 □ Yes 2🂢 No                           | an', Mexican, Puèrto<br>Specify:               | Rican, etc.)                            | Black, Wh               | ite, etc.<br>IHITE                                 |
| in 72 h<br>n "natu<br>Aedical   | Completed      | (Specify only highe  | t's Education<br>st grade completed)   | 16a. Deced<br>(Give<br>life. I | dent's Usual Occup<br>kind of work done o<br>DO NOT use retired | ation<br>during most of work<br>f)             | ing 16                                  | b. Kind of Busines      | s/Industry   |
| be filed within 7 ntal Hygiene.<br>Ind other than "red other than "red event, the Med   | Com            | Elementary/Secondary (0-12)  | College (1-4or 5+)   |                                | PHARMACI  |  | (E)                                     |                         | MACY   |
| be do star  | To Be          | 17. Father's Name (First, Middle, SAMUEL   | Lastj  | LACHMA                         | AN  | RACHEL   | e (First, Middle, Ma.                   | iden Surname)           | ROLL   |
| 2 sh<br>land<br>is m  |                | 19a. Informant's Name/Relations NINA LACHMAN   |  |                                |   |  | al Route Number, C                      |                         |  |
| es 1 and<br>of Health<br>f item 27<br>r other to  |                | 20a. Method of Disposition  1  Burial 2 □ Cremation  | 20b  | . Place of Dispo               |   | ; 1  |   | c. Location - City of   | -  |
| t. Pa<br>rtmer<br>rtant:<br>rjury   |                | 4 □ Donation 5 □ Other (S  | pecify) A BE   |                                | EMORIAL P   |  | 2/2007 R/                               |                         |  |
| permi<br>Depa<br>Impo<br>any Ir   |                | ) S  | Ell  |                                |   |  | OL LEVINS<br>I ROAD - F                 |                         | S., INC.<br>E, MD 21208                            |
|   |                | 23a. Part1. Enter the disease, or<br>shock, or heart failure. List<br>Immediate Cause (Final   | complications that caused the de only one cause on each line.                          |                                | er the mode of dyin   | g, such as cardiac                             | or respiratory arrest                   | 1                       | Approximate<br>Interval Between<br>Onset and Death |
| /Medical  |                | disease or condition resulting in death)   | Due to (or as a conse  | equence of):                   |   |  |   |                         | 5 days   |
| Examiner  | er             | Sequentially list conditions,  | b. End Stag  |                                | A Disease   | ೬  |   |                         | 1 month  |
| ecuted<br>and<br>transit  | Examiner       | Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c  | aguaraa afti                   |   |  |   |                         |  |
| tificate be executed<br>ig physician and<br>as the burial-transit   | edical E       |  | d.   | equence on.                    |   |  |   |                         |  |
|   |                | IF FEMALE:   | 23c. If yes, outcome pf preg   | nancy                          |   |  |   |                         |  |
| the death cert<br>by the attending<br>ached for use   | Physician/N    | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 1 □ Live birth 2 □ Fe<br>4 □ Pregnant at time of<br>9 □ Unknown                        | etai death 3                   | Ectopic pregnancy<br>Other <i>(specify)</i>                     |  |   | 23d. Date of d<br>Month | elivery<br>Day Year                                |
| e law requires that the de<br>has been signed by the<br>ge 2 should be detached   |                |  | ons contributing to death but not re   | -                              |   |  |   |                         | to the cause of death?                             |
| in requi  | Completed by   | Diabetes Mell  |  | 11110000                       | Resports  |  | 1 ☐ Yes<br>24a, Was an                  |                         | Probably 4 Unknown autopsy findings available      |
| sician: T'e la<br>certificate had<br>irector, page 2  | Comp           | coronary arte  |  |                                |   |  | autopsy<br>performe<br>1∐ Yes 2         | prior to                | completion of cause of                             |
| /slclan<br>s certific<br>director,  | Be             | 25. Was case referred to medica examiner? 1 ☐ Yes 2☐ No  | Hospital:  | ☐ ER/Outpatien                 | t 3 DOA Othe  | or.  | h (Check only one)                      | a 6 DOthor (Sr          | ionifu)  |
| ing Phy<br>After thi<br>uneral c  | on: To         | 27. Manner of Death  1  Natural 5  Pendin  | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of                   | 28c. Injur<br>Worl  | y at   | 28d. Describe how                       |                         | вспу)  |
| or Attend<br>after death<br>Director: /<br>in by the f  | Certification: | 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ  | not be as Place of injury At   | home, farm, stre<br>cify)      |   | Yes 2 □No                                      | 28f. Location (Stree<br>City or Town, S |                         | Rural Route Number,                                |
| To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death.  To the Funeral Director: After this certificate has the signed by the attendir completely filled in by the funeral director, page 2 should be detached for use | Medical Co     |  | g Physician: To the best of my k<br>Examiner: On the basis of examinand manner stated. |                                |   |  |   |                         |  |
| To th<br>withir<br>To th  | Me             | 29b. Signature and title of certifie   | a C Cur  |                                | 29c. License  | - 0 0 0  |   | Date signed (Mo         |  |
| 7   |                | 30. Name and address of person (helsea C. Pink   | who completed cause of death (Ite  | em 23a) (Type,                 | Print)  | 1 of Bai                                       | timove                                  |                         |  |
| Sta   |                | 31. Date filed (Month, Day, Year)  | 20 Posiotrada Cis  | nature                         | reeles  | · VI DUL                                       | CIVILLY C                               |                         |  |
| Registr   |                | AUG I  | # 7001 P   | The Sale                       | 1000  |  |   |                         |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MACARE VICH 10:02 AM HNTHON **Physician** STANIE 13, 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Hospital Bel Air Upper Chesapeake If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 10M 20F 219-26-529 Jan. 11, 1939 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State 28a-f show "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 ☑ No Director mp Hartor voppatowne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2 any injury or other traumatic event, the Mesteral Examiner must be n USA Ferguson 21085 712 by Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) reledyne Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bart Macarevich 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) mo 21085 lacarevict Vwite 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Forest Hill, MD -15-2007 Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Ferrans Funeral chapel & Cremation 21. Signatur of Funeral Service Li Ilmbe Services-Belair 3 Newport Dr. Forestitill mo 21050 e, or complications triat caused the dr ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onserand Beat 23a. Part1. Enter the dise shock, or heart failu Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed bunial-transi Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician as the attending I for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) ed by the a ☐ Yes 2☐ No 9 Unknown been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Dhknown 1 Yes 2 No 3 Probably Completed Were autopsy findings available prior to completion of cadse of death? 1 □ Yes 2 □ No 24a. Was an autopsy has page 2 2(1) 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certifica completely filled in by the funeral director, p 25. Was case referred to local examiner? 1 Yes 2 Yes 26. Place of Death Check onl on Medical Certification: To Be Other: 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Desidence 6 □Other (Specify) 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner Death 28c. Injury at Work? (Month, Day Year) Injury 1 tural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 🛮 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) HUNS 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

40

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year) AUG 1 4 2007

0120

Downs

son who completed cause of death (Item 23a) (Type, Print)

3 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 10:50 A<sup>M</sup> Ernest J. Mason August 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 12 M 2□F 71 271-36-3437 July 19, 1936 Ohio Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1√Yes 2 No Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1200 Delaware Avenue 20024 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify: Specify: Black 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Patient Escort Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith E. Byrd/Son 7962 Silverado Place, Alexandria, VA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 8/7/2007 Odenton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hy art failure. List only one care on each line.

Immediate Carrie (Final disease or condition resulting in death)

a. Polymicrobial Pneumonia 313 Talbott Avenue, Laurel, MD Approximate Interval Between Onset and Death 3 weeks Due to (or as a consequence of): Serticemia 3 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Infected Multiple Decubiti 2 months Due to (or as a consequence of): End Stage Dementia 6 months IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Respiratory Failure 1 ☐ Yes 2 ☐ No XX Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No CVA 24a. Was an 1□ Yes 2√√ No 2√ No Ischemic Cardiomyopathy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Manatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 K Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

death certificate be executed Box 68760 P.0. Records, Division or Vital Hospital or Attending **Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed

Be

2

Examiner

Physician/Medical

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Completed

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Certification:

Medical

29b. Signature

MIchael

31. Date filed (Month, Day, Year)

and title of certifier

Baako,

AUG 1 4

C) 75 -

32 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

**Physician** 

/Medical

burial-transit

as

detached

page 2 should

funeral director

filled in by the

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peen

certificate has

this

After

24 hours after death.

within 2.

physician

Examiner

Baltimore, Maryland 21215-0036

Registrar

7300 Van Dusen Road, Laurel, MD

29c. License number D0057216 29d. Date signed (Month, Day, Year)

August 2, 2007

20707

26050

|                            |  |                | 1 = State Registrar  | Ce                                | rtificate of L   | Death                                      | iornai rij                             | Reg. No.                          | 2001                                 | 20000                                     |
|----------------------------|--|----------------|--|-----------------------------------|--|--|--|-----------------------------------|--------------------------------------|---|
| 44                         | Physici  | an             | 1. Decedent's Name (First, Middle, Last)   |                                   |  |  | 2. Date of D                           | eath<br>Day                       | Year                                 | 3. Time of Death                          |
|                            | /Medi  |                | Arnold Wade Minnick Jr.  |                                   |  |  | Augu                                   | st 1                              | 2,2007                               | 11:15 PM                                  |
|                            | Examir   | ner            | 4a. Facility Name (If not institution, give street and number)   |                                   |  | Location of Death                          |  |                                   | County of Death                      |   |
|                            | ······································   |                | 9110 Chesapeake Avenue   | for and to findle of a co         |  | s Island                                   |  | 1                                 | Baltimo                              |   |
| Ŀ                          | Funeral<br>Director  |                | 5. Social Security Number  217-52-6601  Usual Residence of Decedent  6. Sex 1 □ X M 2 □ F  5  Usual Residence of Decedent  |                                   | Months Days  | Hours Min.                                 | 8. Date of Bi<br>(Month, Di<br>Februar | rth<br>ay, <i>Year)</i><br>y 19,1 | 950 9. Birth                         | place (State or Foreign<br>ntry)<br>rland |
|                            | land<br>ow<br>t  |                |  | ity, Town or Lo                   | ocation  |  |  |                                   |                                      | 10d. Inside City Limits                   |
|                            | Mary<br>f sho  | to             | Maryland Baltimore   | Miller                            | s Island   |  |  |                                   |                                      | 1 ☐ Yes 2 ☐ No                            |
|                            | r 28a  | Director       | 10e. Street and Number   |                                   | 10f. Zip Code  |  |  | 10g. Citiz                        | zen of What Cou                      | ntry?                                     |
|                            | th with  | a D            | 9110 Chesapeake Avenue   |                                   | 2121   | 9  |  | τ                                 | JSA                                  |   |
|                            | ems<br>er mu   | Funeral        | 11. Marital Status 12. Was Decedent Ever in U. Armed Forces?   | J.S. 13.                          | Was Decedent of Hi<br>If Yes, specify Cuba                       | spanic Origin? (Spanic Origin?)            | ecify Yes or N                         | 0-                                | 14. Race - Americ<br>Black, White,   |   |
| Maryland 21215-0036        | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>he Medical Examiner must be notified at | by             | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:   |                                   | 1□Yes 2⊠No   |  | r noarn, Geo./                         |                                   |                                      | ite                                       |
| 5-                         | be filed within 72 ho<br>ntal Hygiene.<br>id other than "natui<br>event, the Medical   | Completed      | 15. Decedent's Education<br>(Specify only highest grade completed)   | 16a. Dece<br>(Give                | dent's Usual Occupa<br>kind of work done o<br>DO NOT use retired | ation<br>Juring most of works              | ing                                    | 16b. Kir                          | nd of Business/In                    | dustry                                    |
| 121                        | vithin<br>sne.<br>than   | ם              | Elementary/Secondary (0-12) College (1-4or 5+)   |                                   |  |  |  | Cor                               | struction                            | on  |
| 2                          | filed withi<br>Hygiene.<br>ther than   | ပိ             | 12 years  17. Father's Name (First, Middle, Last)  | LI.                               | ane Opera  | 18. Mother's Name                          | /Eirot Middle                          |                                   |                                      |   |
| an                         | d be   | ) Be           | Arnold Wade Minnick Sr.  |                                   |  |  | eth Ja                                 |                                   | ,                                    |   |
| 2                          | should<br>ind Men<br>marke   | P              | 19a. Informant's Name/Relationship (Type. Print)   | 19h. Mailiu                       | ng Address (Street a   |  |  |                                   |                                      | Code                                      |
|                            | es 1 and 2 should be filed of Heath and Mental Hygion of Heath and Mental Hygion filem 27 Is marked other other traumatic event, the           |                | Mary Sharon Warner sister  | 471 1                             | Wrights L  | ane, Balt                                  | imore,                                 | Mary                              | yland 2                              | 1221                                      |
| Baltimore,                 | permit. Pages: Department of F Important: If ite any injury or of  |                | 1 ☐ Burial 2 【**Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  | cemetery, crei<br>yview           | natory or other place<br>Crematory                               | 200  |  | Balt                              | cation - City or To                  | ity, MD.                                  |
| Bal                        | permit<br>Depar<br>Impor<br>any in   |                | 21. Signature of Funeral/Service Licensee  | al de                             | Onnelly F<br>110 Solle:  | uneral Ho<br>rs Point                      | me Of<br>Road,                         | Dunda<br>Dunda                    | alk,P.A.<br>alk, MD.                 | 21222                                     |
|                            |  |                | 23a. Part T. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.   | th. Donot ent                     | er the mode of dying   | g, such as cardiac                         | r respiratory a                        | arrest,                           |                                      | Approximate<br>Interval Between           |
|                            | Physician  |                | Immediate Cause (Final disease or condition  | adule                             | a paro   | enter !                                    | مرا                                    | -                                 |                                      | Onset and Death                           |
| 1                          | /Medical<br>Examiner   |                | resulting in death)  Due to (or as a consequence)  | quence of):                       | U  |  |  |                                   |                                      |   |
| ш                          | Examiner   | _              | Sequentially list conditions, b.   |                                   |  |  |  |                                   |                                      |   |
|                            | ed sit   | Jine           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | luence of):                       |  |  |  |                                   |                                      |   |
| 03.                        | be executed<br>sician and<br>buriat-transit  | Examiner       | that initiated events resulting in death) Last C Due to (or as a conseq  | uence of):                        |  |  |  |                                   |                                      |   |
| 68766                      | sician<br>buris  |                |  |                                   |  |  |  |                                   |                                      |   |
| 89                         | certificate ding physise as the b  | Medical        | d  |                                   |  |  |  |                                   |                                      |   |
| P.O. Box                   | attene<br>for us   | Physician/M    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown | al death 3□                       | Ectopic pregnancy Other (specify)                                |  |  | 2                                 | 3d. Date of delive<br>Month          | ery<br>Day Year                           |
|                            | w requires that the d<br>been signed by the<br>should be detached  | / Ph           | Part II. Other significant conditions contributing to death but not resi   | sulting in the w                  | nderlying cause give   | en in Part I.                              | 23e. Did                               | tobacco us                        | se contribute to the                 | he cause of death?                        |
| ds                         | luires<br>sign<br>ld be  | d by           |  |                                   |  |  | 1 🗆                                    | Yes 2                             | <b>∡</b> No 3 □ Prot                 | pably 4 ∐Unknown                          |
| Ö                          |  | lete           |  |                                   |  |  | 24a. Was                               | an                                | 24h Were auto                        | ppsy findings available                   |
| Division or Vital Records, | ilcian: The law<br>certificate has b<br>ector, page 2 sl   | Completed      |  |                                   |  |  | auto<br>perfi<br>1□ Yes                | psy<br>ormed?<br>2⊠No             | prior to co<br>death?<br>1 ☐ Yes     | mpletion of cause of                      |
| ₹                          |  | ) Be           | 25. Was case referred to medical examiner?  1 ☐ Yes 2 → No  Hospital: 1 ☐ Inpatient 2 ☐  | 15D/O-+                           | ot 3 DOA Othe  | 26. Place of Death                         |  |                                   |                                      |   |
| o                          | Physer this eral dii   | - To           | 27. Manner of Death 28a. Date of Injury  | ER/Outpatien<br>28b. Time of      | . 0 50/1   | 4 Li Nutsing no                            | me 5 Hes<br>28d. Describe              |                                   | Other (Specif                        | ý)  |
| lon                        | Attending Phyrdeath. ector: After thi  | Certification: | Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation   | Injury                            |  | ?<br>/es 2 \( \subseteq No                 |  |                                   | ,                                    |   |
| <u> S</u>                  | Atter<br>r dea<br>ector<br>by the  | ifica          | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specif  | ome, farm, str                    | eet, factory, office   |  | 28f. Location (                        | Street and                        | d Number or Rura                     | al Route Number,                          |
| Ö                          | al or A<br>s after<br>al Direction by  | Sert           | 4 Intrinside building, etc. (Specify   | ny)                               |  |  | City or 10                             | wn, State)                        | 1                                    |   |
|                            | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu                     | edical (       | 29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of my kno 2 ☐ Medical Examiner: On the basis of examina and manner stated.                                      | owledge, deatl<br>ation and/or in | h occurred at the tim<br>vestigation, in my of                   | ne, date and place,<br>pinion, death occur | and due to the<br>red at the time      | cause(s)<br>, date and            | and manner as s<br>place, and due to | stated.<br>to the cause(s)                |
|                            | To the within To the Comple  | Me             | 29b. Signature and title of certifier  |                                   | 29c. License   | number                                     |  | - 6                               | e signed (Month,                     | Day, Year)                                |
|                            |  |                | > m horself  |                                   | 1197   | 14   |  | 8/13/                             | 107                                  |   |
|                            | 2  | 5              | 30. Name and address of person who completed cause of death (item M CHNZL PVP V) JYPV N C Y  | n 23a) (Type,                     | Print) SPERT   | AVE  | BALTIN                                 | nre                               | MD 21                                | 224                                       |
|                            | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year) 32 Tealstrar's Signal AUG 1 4 2007   | ature                             |  | , ,  |  |                                   | , ,                                  |   |
|                            | ogioti   |                | CIUU A I COU! Salaka d   | OF ESO                            | SAGE 1   |  |  |                                   |                                      |   |

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fb 9870 8-16-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MILNE **Physician** Q /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Annapolis <u>Anne</u> Arundel 8. Date of Birth (Month, Day, Year) Dec 30,1934 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Scotland 6. Sex **Funeral** Months Days 1 □ M 2 X F 001 30 0915 72 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland | Anne Arundel Director Lothian 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1022 Marlboro Road 20711 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 😾 🏌 lo Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) Henry O'Neill 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Hill ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dick Milne (Husband) 1022 Marlboro Road, Lothian, MD 20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Kurial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer I San ce Lin 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificate be executed physician and the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending pt for use as tl IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has the inector, page 2 s autopsy 1∐ Yes 32 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated Signature and title of certific who completed cause of death (Item 23a) (Type, Print 10 31. Date filed (Month, Day, Year) 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

AUG 1 4

Physicia /Medic Examin

**Funeral** Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

|                                  | 1 - For State Registrar   |   | -  | Certificate                           |                            |                                 | Mentann                           | Reg. N              | 20              | 117                      | 26060                                       |
|----------------------------------|---|---|--|---------------------------------------|----------------------------|---------------------------------|-----------------------------------|---------------------|-----------------|--------------------------|---|
|                                  | 1. Decedent's Name (First, Middl  | e, Last)  |  |                                       |                            |                                 | 2. Date of I                      |                     | Day             | Year                     | 3. Time of Death                            |
| in<br>al                         | JAMES FREDERIC  | CK MILLER, SR   |  |                                       |                            |                                 | AUG.                              |                     | 11              | 2007                     | 7:09P <sup>M</sup>                          |
| er                               | 4a. Facility Name (If not institution   | n, give street and number)  |  | 4b. City,                             | Town, or L                 | ocation of Dea                  | th                                | 4                   | tc. Count       | y of Death               |   |
| 6                                | 1214 BRANCH LA  |   |  |                                       | BURN                       |                                 |                                   |                     | ANNE            | ARUNI                    | DEL   |
|                                  | 5. Social Security Number  215-18-7001  Usual Residence of Decedent                     | 6. Sex 7. Ag  | e (In yrs. last birth                      | rs. If Under Months                   |                            | If Under 24 Hrs<br>Hours Min    |                                   | Day, Yea            | 924             | 9. Birthpi<br>Coun<br>MD | lace (State or Foreign<br>try)              |
|                                  | 10a. State 10b. County  |   | 10c. City, Town                            | or Location                           |                            |                                 |                                   |                     |                 | 11                       | 0d. Inside City Limits                      |
| 힏                                | MD ANNE A   | RUNDEL  | GLEN BUR                                   | NIE                                   |                            |                                 |                                   |                     |                 |                          | 1 ☐ Yes 2 No                                |
| rec                              | 10e. Street and Number  | TRONDLI   | GLLN DOI                                   | 10f. Zip                              | Code                       |                                 |                                   | 10g. (              | Citizen of      | What Coun                | itry?                                       |
| ral D                            | 1214 BRANCH LA  | NE  |  | 210                                   | 61                         |                                 |                                   | US.                 | A               |                          |   |
| ne                               | 11. Marital Status  | 12. Was Decedent<br>Armed Forces?                                       |  | 13. Was Deced                         | lent of Hisp<br>cify Cuban | oanic Origin? (<br>Mexican, Pue | Specify Yes or North Rican, etc.) | 10-                 |                 | ce - Americack, White,   |   |
| Be Completed by Funeral Director | 1 □ Never Married 2 □ Marri<br>3 ሺ Widowed 4 □ Divorced                                 | If Vac Give   | No   | 1 ☐ Yes                               | 3737                       | Specify:                        |                                   |                     | Speci           | TITLE                    |   |
| etec                             | 15. Deceden   | nt's Education<br>est grade completed)                                  | 16a. I                                     | Decedent's Usua<br>(Give kind of wo   | al Occupati                | on<br>ring most of w            | orkina                            | 16b.                | Kind of E       | Business/Inc             | dustry                                      |
| nple                             | Elementary/Secondary (0-12)   | College (1-4or 5  | 5+)  | life. DO NOT us                       | e retired)                 |                                 | 9                                 | n                   |                 | CIDIT.                   |   |
| ပ္ပံ                             | /   |   | MIL  | KMAN                                  |                            |                                 |                                   |                     | ELIV            |                          |   |
| Be                               | 17. Father's Name (First, Middle,   | Last)   |  |                                       | 1                          | 8. Mother's Na                  | me (First, Midd                   | le, Maid            | en Surna        | me)                      |   |
| P.                               | JAMES FREDERIC  | CK MILLER   |  |                                       | F                          | LORENC                          | E BREUN                           | ING                 |                 |                          |   |
|                                  | 19a. Informant's Name/Relations   | ship (Type. Print)  | 19b.                                       | Mailing Address                       | (Street an                 | d Number or F                   | Rural Route Nun                   | ber, Cit            | y or Town       | , State, Zip             | Code)                                       |
|                                  | MR. JAMES F. M  | ILLER, JR/SON   | _  | IGHTH A                               |                            | BROOKL                          |                                   |                     |                 |                          |   |
|                                  | 20a. Method of Disposition 1 ▼Burial 2 □ Cremation 4 □ Donation 5 □ Other (S            |   | cemetery                                   | Disposition (Nan<br>v, crematory or o | ther place)                | HUG                             | . 16,                             |                     |                 | - City or To<br>VILLE ,  |   |
|                                  | 21. Signature of Funeral Service  |   | / VE10                                     | 22. Name an                           |                            |                                 |                                   |                     |                 | VE. SV                   |   |
|                                  | 1345  | a moi   | 3/04                                       | SINGLET                               | ON FU                      | NERAL I                         | HOME; GI                          |                     |                 |                          |   |
| 177                              | 23a. Part1, Enter the disease, or   | r complications that caused   | the death. Do no                           | -                                     |                            |                                 |                                   |                     | 97              |                          | Approximate                                 |
|                                  | shock, or heart failure. List<br>Immediate Cause (Final                                 | t only one cause on each li   | ADII                                       | 10-1-12                               | W 1/                       | 1/1/1                           | CI                                |                     |                 |                          | Interval Between<br>Onset and Death         |
|                                  | diseese or condition resulting in death)  | a. Due to for as  | a consequence of                           | TRIER                                 | 10                         | WEA                             | 16                                |                     |                 |                          | 5 year                                      |
|                                  |   | Due to (or as   | a consequence o                            | 1).                                   |                            |                                 |                                   |                     |                 |                          |   |
| e                                | Sequentially list conditions, if any, leading to immediate                              | b. Due to (or as  | a consequence of                           | f):                                   |                            | _                               |                                   |                     |                 |                          |   |
| m                                | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events            | <b>S</b> .  |  |                                       |                            |                                 |                                   |                     |                 |                          |   |
| Exa                              | resulting in death) Last  | Due to (or as   | a consequence of                           | f):                                   |                            |                                 |                                   |                     |                 |                          |   |
| ledical Examiner                 |   | <b>L</b> d  |  |                                       |                            |                                 |                                   |                     |                 |                          |   |
| edi                              |   | 2.00  |  |                                       |                            |                                 |                                   |                     |                 |                          |   |
| Completed by Physician/N         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome<br>1 ☐Live birth<br>4 ☐ Pregnant at<br>9 ☐ Unknown | 2 Fetal death                              | 3 □Ectopic pr<br>5 □ Other (sp        |                            |                                 |                                   |                     |                 | ate of delive<br>lonth   | ery<br>Day Year                             |
| Y P                              | Part II. Other significant conditi  | ons contributing to death b   | ut not resulting in                        | the underlying c                      | ause given                 | in Part I.                      | 23e. Die                          | d tobacc            | o use cor       | ntribute to th           | ne cause of death?                          |
| d pa                             |   |   |  |                                       |                            |                                 | 1 [                               | Yes                 | 2 No            | <b>3</b> ☐ Prob          | ably 4 Unknown                              |
| ple                              |   |   |  |                                       |                            |                                 | 24a. Wa                           | as an<br>topsy      | 24b             | . Were auto              | psy findings available mpletion of cause of |
| E O                              |   |   |  |                                       |                            |                                 | pe<br>1⊡ Yes                      | formed'             |                 | death?                   | 2 ANO                                       |
| Be                               | 25. Was case referred to medica examiner?   | al  |  |                                       | - 1                        | 26. Place of De                 | eath (Check only                  |                     |                 |                          |   |
| 0                                | 1 Yes 2 No  | Hospital: 1 ☐ Inpatie   | ent 2 ER/Out                               | oatient 3 DC                          | A Other                    | 4 ☐ Nursing                     | Home 5                            | Sidence             | 6 🗆 01          | her (Specify             | y)  |
| ü                                | 27. Manner of Death 1 ☐ Natural 5 ☐ Pendir  | 28a. Date of Inju<br>(Month, Da   |  | me of 2<br>jury                       | 8c. Injury a<br>Work?      | at                              | 28d. Describ                      | e how in            | jury occu       | rred                     |   |
| atic                             | 2 Accident investi  | gation  |  | М                                     |                            | es 2 No                         |                                   |                     |                 |                          |   |
| ertific                          | 3 ☐ Suicide 6 ☐ Could determ  |   | ury - At home, farı<br>c. <i>(Specify)</i> | m, street, factory                    | , office                   |                                 | 28f. Location<br>City or 7        | _(Street<br>own, St | and Num<br>ate) | ber or Rura              | l Route Number,                             |
| Medical Certification: To        |   | ng Physiclan: To the best<br>Examiner: On the basis o<br>and manner sta | f examination and                          |                                       |                            |                                 |                                   |                     |                 |                          |   |
| Ž                                | 29b. Signature and title of certification   | blat  | 2 m  | 290                                   | License                    | number<br>-00 9 (               | (                                 | 29d. [              | Date sign       | ed (Month, 13/0          | Day, Year)                                  |
|                                  | 30. Name and address of Gerson  | bary and.   | 141) M                                     | Type, Print)                          | Park                       | Bra                             | of Gl                             | al                  | whi             | f, m                     | d, 2106/                                    |
| e<br>ar                          | 31. Date filed (Month, Day, Year)  AUG 1 4  | 2007 32. Régistr  | ar's Signature                             | certi                                 |                            |                                 | (                                 |                     |                 | 4                        |   |

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Sta Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:49 A 6,200 Dennis /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ( DYP) Westminster ente Hospita If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F 55 215-58-1783 Yrs Director Aug 12, 1951 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√☐ No MD Carrol1 Westminster Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 Is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be a 27 E. Main Street #306 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) carpenter home improvements 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Kenneth Myers Catharine Irine Bankert ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau Carroll Hospital Center 200 Memorial Avenue Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) State Anatomy Wade, Board 655 W. Baltimore Street Baltimore, MĎ 21201 23a. Part I Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate O se (Final **Physician** neumonia 03/5 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metosta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and I for use as the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the at Id be detached for 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy perform certificate 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mannel of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

State

30. Name and addre s of person who com

31. Date filed (Month, Day, Year)

onno (

AUG 1 4

2007

med cause of death (Item 23a) (Type, Print)

Stener

295

32 Registrar's Signatur

6,2007

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                |   | 1                                   | For State Registrar  | tate of Maryland / Department of<br>Certificate of   |   | lental Hygien<br>Reg. N  |  | 26062   |
|--------------------------------|---|-------------------------------------|--|--|---|--|--|---|
|                                | Physicia  | an                                  | Decedent's Name (First, Middle, Last)  | Nolson   |   | 2. Date of Death   | ay Year 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7  | 3. Time of Death AM   |
|                                | /Medic<br>Examin<br>Funeral<br>Director   | er                                  | a. Facility Name (If not institution, one stre<br>GENESI'S Ray da STO<br>5. Social Security Number 6. Sex<br>1 1 M   | un 9109 Liberty Road<br>7. Age (In yrs. last birthday) If Under 1 Y  | rear If Under 24 Hrs. ays Hours Min.  | 8. Date of Birth<br>(Month, Day, Year  | Bal+(MC) 9. Birthp   | one Gunty place (State or Foreign) RGINIA   |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other traumatic event, I'm Medical Examinar must be notified at once. | To Be Completed by Funeral Director | 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educati (Specify only highest grade of Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  19a. Informant's Name/Relationship (Type, DE / FSE/  20a. Method of Disposition 10 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)  21. Synature of Funeral Service Licensee | Tyes 2   No  | to of Hispanic Origin? (Specuban, Mexican, Puerto Cuban, Mexican, Puerto Cocupation fone during most of work retired)  18. Mother's Name of Control of the Control of Taylore)  Address of rigility (SA)  Address of rigility (SA)  Address of Fault (SA) | al Route Number, City ARE 100.  AGER AD  AGER AD | 14. Race - America Black, White, Specify: BL Kind of Business/Inc.  CLIT DISABI an Sumame) | Code)  Depth of the second of |
| 8760,                          | ate be executed hysician and hysician and Examiner transit the buriat-transit   | ai Examiner                         | 23a and 1. Enter the disease, or complicat shock, or heart failure. List only one of the complete shock, or heart failure. List only one of the complete shock of the conditions of the conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                               | ons that caused the death. Do not enter the mode of ause on each line.  OF OND TY OF O | of dying, such as cardiac<br>disease<br>disease   | or respiratory alrest,   |  | Approximate<br>Interval Between<br>Onset and Death  |
| O. Box 6                       | The law requires that the death certificate ale has been signed by the attending physpace 2 should be detached for use as the   | Completed by Physician/Medical      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | If yes, outcome of pregnancy 1   |   |  | 23d. Date of deliv<br>Month  | rery<br>Day Year  |
| cords, P.                      | recuir<br>been s<br>should  | pleted by Pl                        | Part II. Other significant conditions contri   | outing to death but not resulting in the underlying cau  | se given in Part I.   |  |  | the cause of death?  bably 4 Unknown  opsy findings available ompletion of cause of   |
| ital Re                        |   | 0                                   | 25. Was case referred to medical   |  | 26. Place of Dea  | performed 1 Yes 2 Att (Check only one)   | ? death?   |   |
| Division of Vital Records,     | ng Phys<br>fter this<br>ineral di   | Certification; To B                 | 27. Manner of Death  1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be   | oital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA  28a. Date of Injury (Month, Day Year)  28b. Time of Injury M  28c. Place of Injury - At home, farm, street, factory, c   | c, Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No   | ome 5 Residence 28d. Describe how in 28f. Location (Street   | ijury occurred  and Number or Rur  |   |
| Div                            | To the Hospitel or Attendi<br>within 24 hours after death.<br>To the Funerel Director: A<br>completely filled in by the fu  |                                     | 4 Homicide  4 Homicide  29a. Certifier (Check only 2 Medical Examine)  | building, etc. (Specify)  an: To the best of my knowledge, death occurred at: On the basis of examination and/or investigation, in   | the time, date and place  | City or Town, Sta  | a(s) and manner as:  | stated.   |
|                                | To the H<br>within 24<br>To the Fi<br>complete  | Medical                             | 29b. Signature and little of secrition   | and manner stated.   | License number  |  | Date signed (Month   |   |
| 3                              | St.<br>Regist   | ate<br>rar                          | 30. Name and address of person who com  31. Date filed (Month, Day Year)   | sound of death (Item 23a) (Type, Print)  Sound of Og Ul  32. Redistrar's Signature   | perty Roc   | ad, Rand   | dallst   | wn, MD<br>21133   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:50a м Κ. Owens August 12, 2007 Jean /Medical 4a. Facility Name (If not institution, give street and number)
418 Megan Court 4b. City, Town, or Location of Death Frederick 4c. County of Death Frederick Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 9,1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 ☐ M 2 🔀 F 190-16-5833 84 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Silver Spring MD Montgomery 1 XYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 USA 3322 Chiswick Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married 2 X No White 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Devorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Defense Department <u>Budget Analyst</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leah E. Whiteman John W. Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 418 Megan Court, Frederick, MD 21701 John Owens / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State North Forest Cemetery 8/22/2007 Marienville, PA 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Charles L. Stevens Funeral Home Inc. 1501 East Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) 18 months Gastroesophageal Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Winknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1∐ Yes 2. XXNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) son's house 1 Yes 2X No To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed burial-transit Division or Vital Records, P.O. Box 68760, the attending pl ed by the a has been signed to the second page the Hospital or Attending Physician; funeral director, After this death. within 24 hours after death

To the Funeral Director completely filled in by the f

**Funeral** 

Director

r 28a-f show notified at

ms 23a or

"natural", or items

the Medical

other than

permit. Pages 1 and 2. Department of Health a Important; If item 27 Is any injury or other trauonce.

Physician /Medical

Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number

D - 0058893

29d. Date signed (Month, Day, Year) August 14, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. Browner. MD 5505

Hapkins Bayview Grale

Baltimore, MO 21224

State Registrar 31. Date filed (Month, Day, Year) **AUG 1 4** 2007



MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician ODOM rua 200 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ON N/A If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 ☐ F VIRGINIA 11-11-1933 215-30-9076 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 ☐Yes 2 ☐ No Examiner must be notified Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 827 ARLINGTON AVE. APT 707 21217 USA items 23a Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 → Never Married 2 Married 0 BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12)
-10-College (1-4or 5+) s 1 and 2 should be filed within thealth and Mental Hygiene. Item 27 is marked other than COOK FOOD -0-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ JEWEL ODOMS MADORA GALLMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) VALERIE ODOMS (DAUGHTER) 6461 WOODGREEN CIRCLE BALTIMORE, MARYLAND 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Iter 1 Durial 2 Cremation 3 Removal from State 9 GARRISON FOREST VETERANS 8-17-2007 OWINGS MILLS, MARYLAND 4 Donation 5 ☐ Other (Specify) any Injury HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedi Cause (Final disease r condition ardio Vazcular nearl Physician /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and I-transit certificate be executed Due to (or as a consequence of) as the burial-P.O. Box 68760, attending physician Physician/Medical IF FEMALE for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the aid be detached for 2 🗆 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of eause of death?

1 Yes 2 No 24a. Was an has 1□ Yes 2 NO completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 2 ER/Outpatient 3 DOA 1 🗌 Yes 1 Inpatient P this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 1- Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No death. To the Hospital or Attend within 24 hours after death. To the Funeral Director 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 003035 mpleted cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

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2007

31. Date filed (Month, Day, Year)

AUG 1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** rice zabeth 200' /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner peake Medical Center If Under 1 Year | If Under 24 Hrs.
Months | Days | House 1 | House Har tord Birthplace (State or Foreign Country) 6. Sex **Funeral** 1□M 2**X**F BACTIMORE, MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No MD Director Has 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code SF 2116 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced White Year or Dates: 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Imporant: If Item 27 is marked other the any injury or other traumatic event, the once. omenia nome 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 [ [ [ ] Kd. rall-daughter Baltimore, 20). Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill 22. Name and Address of Facility 3 New port Dr. Forest Hill 21. Signature of Funeral Service Evans Fundal Chapel- Cremation Services Bel hise, or complications that caused the death. Do not enter the mode of dying, such as card ic or respiratory arrest, e. List only one cause on significant control of the c an1. Enter the dis-shock, or heart fail Immediate Cause (Final disease or condition resulting in death) **Physician** tomina /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an perfor 1□ Yes Viital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA After this Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2∏No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) D0066102 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 500 Upper Chesapeake Dr. Be 31. Date filed (Month, Day, Year) egistrar's Signature State Registrar

|                     |  |                | 1 - For<br>State<br>Registrar  | State of N                                 | /larylar           |                              |                     |                           | lealth a<br>Death |            | lental Hy                      | /gienę<br>Reg. No. | 7 (1)        | 17                    | 26066  |
|---------------------|--|----------------|--|--|--------------------|------------------------------|---------------------|---------------------------|-------------------|------------|--------------------------------|--------------------|--------------|-----------------------|--|
|                     |  | ž              | Negistral     Necedent's Name (First, Middle, La.  | st)  |                    |                              |                     |                           |                   |            | 2. Date of De                  |                    |              |                       | 3. Time of Death                                   |
| ۰                   | Physici  |                | Betty Jane   | Potter                                     |                    |                              |                     |                           |                   |            | Month<br>Augus                 | Day                |              | Year<br>2007          | 12:30 am   |
| No.                 | /Medic   |                | 4a. Facility Name (If not institution, give  |  | r)                 |                              | 4b. Cit             | /. Town. or               | Location of       | of Death   | Mugus                          |                    | <u>-</u> -   | of Death              | 12.30  |
| J.                  | Examin   | er             | Holy Cross Hospi   |  | •/                 |                              |                     |                           | Sprin             |            |                                |                    | -            | tgome                 | rv   |
|                     | - Funanal  |                | 5. Social Security Number 6. S   |  | Age (In vrs.       | last birthday)               |                     | er 1 Year                 | if Under          |            | 8. Date of Bi                  | rth                | 11011        | 0                     | ace (State or Foreign                              |
|                     | Funeral<br>Director  |                |  | □M 2 <b>X</b> F                            | 0 , ,              | 70 Yrs.                      | Months              | Days                      | Hours             | Min.       | (Month, Da<br>April            | av, Year)          | 937          | Count                 | ry)<br>nesota                                      |
|                     | tille statistiques of  |                | Usual Residence of Decedent  |  |                    | 70                           |                     |                           |                   |            | APILI                          | 0, 1               | 731          | 111111                | 103004   |
|                     | /land  |                | 10a. State 10b. County   |  | 10c. Ci            | ty, Town or Lo               | cation              |                           |                   |            |                                |                    |              | 10                    | d. Inside City Limits                              |
|                     | Man-f sh   | to             | Maryland Montgo  | nerv                                       | S                  | ilver                        | Spri                | ne                        |                   |            |                                |                    |              |                       | 1 ☐Yes 2 X No                                      |
|                     | 28a<br>noti  | Director       | 10e. Street and Number   | J  |                    |                              | <del>- i</del>      | ip Code                   |                   |            |                                | 10g. Citi          | zen of W     | /hat Count            | ry?  |
|                     | 3a ol  |                | 11497 Columbia P   | ike  |                    |                              |                     | 2090                      | 4                 |            |                                | 11-                | nite         | d Sta                 | ites   |
|                     | should be filed within 72 hours after death with the Maryland and Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at | Funeral        | 11. Marital Status   | 12. Was Deceder                            | nt Ever in U       | J.S. 13. \                   | Vas Dec             |                           |                   | gin? (Spe  | cify Yes or No<br>Rican, etc.) |                    |              | - America             |  |
|                     | fter c<br>r iter   | Fur            | 1 ☐ Never Married 2 ☐ Married  | Armed Forces 1 ☐ Yes 2 5                   |                    | 1                            |                     |                           | in, Mexicar       | n, Puerto  | Rićan, etc.)                   |                    | Black        | k, White, e           | tc.  |
| Maryland 21215-0036 | al", o   | by             | 3 XWidowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates              | s:                 |                              | 1 ☐ Yes             | 2X No                     | Specify:          |            |                                |                    | Specify.     | Whi                   | te   |
| ş                   | 2 hor  | Completed      | 15. Decedent's Ed  |  |                    | 16a. Deced                   |                     |                           |                   |            |                                | 16b. Ki            | nd of Bu     | siness/Ind            |  |
| 72                  | in "n<br>in "n<br>Medi   | ple            | (Specify only highest gra  | de completed) College (1-4o                | r 54)              | life. l                      | kind of w<br>DO NOT | ork done d<br>use retired | during mos<br>()  | t of worki | ng                             |                    |              |                       |  |
| 7                   | yiene<br>r tha   | E O            | Lioneritary/occorridary (0 12)   | 4  | 101)               | Mea                          | at C                | utter                     |                   |            |                                | F                  | ood          | Servi                 | .ce  |
| g                   | othe<br>ent,   | Be C           | 17. Father's Name (First, Middle, Last,  |  |                    |                              |                     |                           | 18. Mothe         | er's Name  | (First, Middle                 | e, Maiden          | Surnam       | e)                    |  |
| <u>a</u>            | ld be<br>lenta<br><b>ked</b><br>ic ev  | To B           | Wayne William  | Bourcy                                     |                    |                              |                     |                           | Sig               | ne         | Joseph                         | ine                | Eng          | uist                  |  |
| 2                   | 2 shou<br>and M<br>Is mar<br>aumat   | -              | 19a. Informant's Name/Relationship (   |  |                    | 19b. Mailir                  | ng Addre            | s (Street a               |                   | ,          | il Route Numb                  |                    | - 0          |                       | Code)  |
| Š                   | is 1 and 2 should<br>of Health and Mer<br>item 27 Is marke<br>other traumatic  |                | Sally Colgan - Da  | aughter                                    |                    | 11497                        | Co1                 | umbia                     | Pike              | s. Si      | lver S                         | nrin               | ъ. ТМ        | arvla                 | nd 20904   |
| စ်                  | es 1 and 2<br>of Health a<br>item 27 Is<br>r other trau  |                | 20a. Method of Disposition   |  | 20b.               | Place of Dispo               | sition (N           | ame of                    |                   |            | ate                            |                    |              | City or Tov           |  |
| ᅙ                   | ages<br>nt of<br>r: If is  |                | 1 Burial 2 XCremation 3  |  | te                 | cemetery, crer               |                     | ,                         | i                 | 0/0/       | 2007                           | D                  |              |                       |  |
| galtimore,          | permit. Pages 1 Department of H Important: If ite any Injury or otl  | 1              | 4 □ Donation 5 □ Other (Specifical Signature of Funeral Service Licer  |  | FC                 | . Linc                       |                     |                           |                   |            |                                | 1                  |              | 00a,                  | Maryland   |
| g                   | Depa<br>Impo<br>any I  |                | 21. Signature of Fulleral Service Licer  |  |                    |                              |                     |                           |                   |            | ple Tr                         |                    |              | _                     | 1 00050  |
|                     |  | -              | One Part of the diagram  | - U Al Al                                  |                    |                              |                     |                           |                   |            |                                |                    | e, M.        | aryla                 | nd 20852   |
|                     |  | 8              | 23a. Part1 Enter the disease, or com<br>shock, or heart failure. List only   | one cause on each                          | line.              | in. Do not ent               | er the m            | ae or ayın                | g, such as        | cardiac d  | r respiratory a                | arrest,            |              | al.                   | Approximate<br>Interval Between<br>Onset and Death |
|                     | Physician  |                | Immediat C use (Final disease or condition resulting in death)   | a. Respir                                  | atory              | Failu                        | re                  |                           |                   |            |                                |                    |              | 1                     |  |
|                     | /Medical<br>Examiner   |                | resulting in death)  | Due to (or a                               | as a consec        | quence of):                  |                     |                           |                   |            |                                |                    |              |                       |  |
|                     | LAdillillei  | _              | Sequentially list conditions.  | b. Metast                                  |                    |                              | ance                | r                         |                   |            |                                |                    |              |                       |  |
| 1                   | P #  | Examiner       | Sequentially list conditions, if any, leading to mini sortate cause. Enter Underlying Cause (Disease or injury that initiated events | Duri to (or s                              | as a consid        | quence of):                  |                     |                           |                   |            |                                |                    |              |                       |  |
| V                   | ocute<br>nd<br>trans   | am             | Cause (Disease or injury that initiated events   | c  |                    |                              |                     |                           |                   |            |                                |                    |              |                       |  |
| Ď,                  | be executed<br>ician and<br>burial-transit   | ũ              | resulting in death) Last   | Due to (or a                               | as a consec        | quence of):                  |                     |                           |                   |            |                                |                    |              |                       |  |
| 8/60,               | icate be executed<br>physician and<br>s the burial-transit   | dical          |  | _d   |                    |                              |                     |                           |                   |            |                                |                    |              |                       |  |
| ٥                   | rtifica<br>ng ph<br>as ti  | Med            | IE EENAAL E.   |  |                    |                              |                     |                           |                   |            |                                | -                  |              |                       |  |
| X<br>Q<br>Q         | the death certific<br>y the attending p<br>ched for use as   | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcom<br>1□Live birth        | ne pf pregn        |                              | Tectonic            | pregnancy                 |                   |            |                                | ₩.                 |              | e of deliver          |  |
|                     | deat<br>e att  | icis           | in the past 12 months?<br>1 □ Yes 2 ☑ No   | 4□Pregnant                                 | at time of         |                              | Other (             |                           |                   |            |                                |                    | Mor          | nth [                 | Day Year   |
| j.                  | t the<br>by th<br>ache   | hys            | 9 Unknown  | 9□Unknown                                  |                    |                              |                     |                           |                   |            |                                |                    |              |                       |  |
| νς.<br>J            | w requires that the de<br>been signed by the s<br>should be detached   | by P           | Part II. Other significant conditions of   | ontributing to death                       | but not res        | sulting in the ur            | nderlying           | cause give                | en in Part I.     | •          | 23e. Did                       | tobacco ι          | ise contr    | ibute to the          | e cause of death?                                  |
| Records,            | quire<br>n sig<br>uld b  | d b            |  |  |                    |                              |                     |                           |                   |            | 1 🖾                            | Yes 2              | □ No         | 3 ☐ Proba             | ably 4 □Unknown                                    |
| ္ပ                  | w re<br>sho  | Completed      |  |  |                    |                              |                     |                           |                   |            | 24a. Was                       | s an               | 24h V        | Vere auton            | sv findings available                              |
| ě                   | The law<br>ate has b<br>page 2 sh  | E C            |  |  |                    |                              |                     |                           |                   |            | auto                           |                    | p            | rior to com<br>leath? | sy findings available<br>pletion of cause of       |
| VITAI               |  |                | OF Man annual to modical   |  |                    |                              |                     |                           |                   |            | 1□ Yes                         | 2 🔀 No             | 1            | ☐Yes :                | 2 🔀 No   |
| 5                   |  | Be             | 25. Was case referred to medical examiner?   | Hospital:                                  |                    |                              |                     | Othe                      | or.               |            | (Check only                    |                    |              |                       |  |
| ō                   | Phys<br>this   | ٦              | 1 ☐ Yes 2X No  27. Manner of Death   | 1 Alnpa                                    |                    | ER/Outpatien<br>28b. Time of |                     |                           | 4 LI Nu           |            | ne 5 Res<br>28d. Describe      |                    |              | 1-7                   | )  |
|                     | After<br>After<br>funera   | ion            | 1⊠Natural 5 ☐ Pending  | (Month, E                                  | Day Year)          | Injury                       | М                   | 28c. Injun<br>Work        |                   |            | ou. Describe                   | now injur          | y occurr     | Bu                    |  |
| UIVISION            | Attending<br>r death.<br>ector: After<br>by the funer  | Certification: | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be  |  | mirror At h        | ome form street              |                     |                           | Yes 2 □ I         |            | 20/ 11                         | (04                | -1.44        |                       | 0-1-11-1   |
| <u> </u>            | or A<br>fter o<br>Direct<br>in by  | Ħ              | 4 ☐ Homicide determined  | 28e. Place of in<br>building,              | etc. <i>(Speci</i> | ty)                          | eet, lacto          | ry, onice                 |                   | 2          | City or To                     | wn, State          | a Numbe<br>) | er or Hurai           | Route Number,                                      |
| _                   | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral   |                | 00-0-4/6   |  | -1 -1 .            |                              |                     | 1 1 2                     |                   |            |                                |                    |              | -                     |  |
|                     | Hos<br>Hos<br>Fune<br>Fune   | Medical        | (Check only 2 Medical Exar   | ysician: To the bes<br>niner: On the basis | of examina         |                              |                     |                           |                   |            |                                |                    |              |                       |  |
|                     | To the within 24 To the Complete   | led            | one)   | and manner                                 | stated.            |                              | _                   |                           |                   |            |                                |                    |              |                       |  |
|                     | 70 Viit  | 2              | 29b. Signature and title of certifier  |  |                    |                              | 2                   | 9c. License               |                   |            |                                |                    |              | l (Month, E           | vay, Year)   |
|                     |  |                | 1 30110  |  |                    |                              |                     | D641                      | 00                |            |                                | 8,                 | 02/2         | 2007                  |  |
|                     | /1   |                | 30. Name and address of person who   | completed cause of                         | death (Iter        | m 23a) (Type,                | Print)              |                           |                   |            |                                |                    |              |                       |  |
|                     | 4  |                | Smitha Bhikkaji,   |  |                    | Forest                       | : G1                | en Ro                     | ad, S             | ilve       | r Spri                         | ng, N              | lary.        | land                  | 20910  |
|                     | Sta  |                | 31. Date filed (Month, Day, Year)  | 32. Regis                                  | strar's Sign       | ature                        |                     |                           |                   |            |                                |                    |              |                       |  |
|                     | Registr  |                | 7310 1 4 ac  | 85   |                    |                              |                     |                           |                   |            |                                |                    |              |                       |  |

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. U 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 4:50 AM OP  $200^{\circ}$ °/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medica Center BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month), Day Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 ☐ F 69 218-32-5970 Usual Residence of Decedent Director 10a. State 10b. County 10c. City, Town or ocation 10d. Inside City Limits "natural", or items 23a or 28a-f shov cdical Examiner must be notified at 1 Pres 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 2 No Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify Completed by 3 Widowed 4 □ Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle Last) Be Beaulah ပ KODINSIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Belationship (Type. Print) Varion Kokinson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Valengania 21. Signatur of Funeral Service MG 51529 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Glioblastoma UNKNOW disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed Hyper tension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perfor certificate Diabetes Yes 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1 lowers ene 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOWERS ADRIENNE 32. Registrar's Signature State Malines Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 2110 PM 11 O 7 4c. County of Death /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** SAMARITAN HOSPITAL BALTU NIA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1**/3**(M 2□F Days Months Hours Min IRGINIA Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 1X Yes 2 No Director 10g Citizen of What Country? 10e. Street and Number by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be LLIAM ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RODRIGUEZ ICE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. I gnature of Funeral Service Licensee ULTON Part 1. Extent the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, be nearl failure. List only one cause on each line. mediate Cause (Final Arrhy **Physician** sease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2**X**(No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2500 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No vithin 24 hours after death fo the Funeral Director; completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a Hospital 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 047 P200H 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DCH RAVEN BLVD, BALTIHORE, MD. 21239 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 7:00 PM ALICE REDFERN 2007 AugusT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F 215-30-798 MARCH 20, 1934 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No Director Citizen of What Country? 10e. Street and Number Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: ģ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical College (1-4or 5+) Is marked other than Elementary/Secondary (0-12) 12+HGRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) f Health item 27 l Baltimore, permit. Pages 1 a
Department of Hes
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State BALTIMORE, 4 □ Donation 5 □ Other (Specify) 22. Name and Address of aci 21. Signature of Funeral Service Licensee , FUNERAL HOME BALTO, MO2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6 Hours INTRACRANIAL HEMORRH AGE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit be executed Due to (or as a consequence of) Box 68760 attending physician Physician/Medical as the IF FEMALE nse 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? for Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a detached f 9☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 Unknown 1 Tyes FIBRILLATION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 □ No 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 TYes Certification; To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 XNatural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

P.O. Division or Vital Records, or Attending

within 24 hours after death To the Funeral Director: Hospital

State Registrar

completely

30. Name and address of pers MARTINE Josep 4 31. Date filed (Month, Day,

4

29a. Certifier

(Check only one)

29b. Signature and title of co

Medical

MD 32. Registrar's Signature

eted cause of death (Item 23a) (Type, Print)

and manner stated.

MD

22 S. GREENE ST. BAUTIMORE

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0060035

29d. Date signed (Month, Day, Year)

21201

|           |   |                  | Please I<br>amei<br>1 - State<br>Registrar   | nd item 26<br>State of Mary  |  | ellole ink<br>e <b>870 8–1</b> 2<br>artment of F<br>tificate of          |   |   | ene () () 7                                    | 26070  |
|-----------|---|------------------|--|--|--|--|---|---|--|--|
|           | Physicia  |                  | Decedent's Name (First, Middle, Last)     Mary C. Reese  | ·  |  |  |   | 2. Date of Death<br>August              | 6 <sup>Day</sup> 2007 <sup>ear</sup>           | 3. Time of Death 1:30 P M                          |
| >         | /Medic<br>Examin  |                  | 4a. Facility Name (If not institution, give s  5 York Court  | street and number)   |  | 4b. City, Town, o  | r Location of Death   |   | 4c. County of Death                            |  |
|           | Funeral<br>Director   |                  | 197-16-0179  | 7. Age (In<br>87   | yrs. last birthday)<br>Yrs.                        | If Under 1 Year<br>Months Days   | If Under 24 Hrs. Hours Min.                                 | 8. Date of Birth<br>NOV • 2 /           | 1917 Penn                                      | place (State or Foreign<br>intry)<br>sylvania      |
|           | Maryland<br>-f show   | tor              | Usual Residence of Decedent  10a. State  10b. County  Pennsylvania Schuy   |  | c. City, Town or Lo                                |  |   |   |  | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No             |
|           | h with the  | Funeral Director | 10e. Street and Number<br>616 Valley Road  |  |  | 10f. Zip Code<br>179   | 01  | 100                                     | g. Citizen of What Cou<br>USA                  | intry?   |
| 999       | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural; or teme 23a or 28e-f show any Injury or other traumatic event, to Medical Examinar must be notified a once. | by               | 11. Marital Status  1 Never Married 2 Married  3 November 4 Divorced   | 12. Was Decedent Ever<br>Armed Forces?<br>1 ☐ Yes ♣☐No<br>If Yes, Give<br>Year or Dates: |  | Was Decedent of H<br>f Yes, specify Cub                                  | dispanic Origin? (Spec<br>an, Mexican, Puerto R<br>Specify: | cify Yes or No-<br>lican, etc.)         | 14. Race - Amer<br>Black, White<br>Specify: Wh |  |
| 0-6171    | within 72 ho<br>ane.<br>than "natur   | Completed        | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0·12)  | cation<br>e com <i>pleted)</i><br>College (1-4or 5+)                                     | (Give  | dent's Usual Occup<br>kind of work done<br>DO NOT use retire<br>Ses Aide | pation<br>during most of working<br>d)                      | g                                       | 6b. Kind of Business/l<br>Health Car           | •  |
| מונת ע    | ld be filed vental Hygie ked other ic event, it   | To Be Co         | 17. Father's Name (First, Middle, Last)  Thomas Mahoney  | 7  | 1  |  | 18. Mother's Name<br>Helen O'C                              | (First, Middle, Ma                      |  |  |
| Mary      | nd 2 shou<br>alth and M<br>27 is mar<br>ir traumat  | <b> -</b>        | 19a. Informant's Name/Relationship (Ty)<br>Sarah Reese—Carter  | •  |  | •  | and Number or Rural   |   | City or Town, State, Z.                        | -  |
| oanimore, | Pages 1 a<br>ment of Hez<br>ant: If Item<br>ury or othe   |                  | 20a. Method of Disposition  1 Burial 2 Cremation 5 XR  4 Donation 5 (Other (Specify)   | amalial from Ctata   | 20b. Place of Dispo<br>cemetery, crer<br>St. Kiera | natory or other pla  | etery08/09/   |   | oc. Location - City or 1 Branch Tow            |  |
| מו        | permit.<br>Departi<br>Import<br>any Inj<br>once.  |                  | 21. Signature of Finer Strice License  | Jews   | Bt 36  | Name and Address<br>179ee—Her<br>531 Falls                               | ss-Seitz H<br>Road, Bal                                     | Tuneral I                               | Home, Inc.<br>Maryland                         |  |
| ار        | Physician<br>/Medical   |                  | 23a. Part . Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)              | END 57   | AGE Q  |  | ng, such as cardiac or                                      |   |  | Approximate<br>Interval Between<br>Onset and Death |
| Å ,00     | be executed xa cicien and purial-transit  | dicai Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a co   | nsequence of):                                     | ERY DI   | SEASE   |   |  |  |
| O. DOA .  | The law requires that the death certificate site has been signed by the attending phys page 2 should be detached for use as the   | Physician/Medi   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 0 No 9 □ Unknown  | 3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown             | Fetal death 3                                      | Ectopic pregnanc Other (specify)   | у   |   | 23d. Date of delin<br>Month                    | very<br>Day Year                                   |
| . Las, L  | quires that<br>en signed by<br>ruld be deta   | ٥                | Part II. Other significant conditions con  | stributing to death but no   | ot resulting in the u                              | nderlying cause gr   | ven in Part I.  | 23e. Did toba                           | acco use contribute to                         | the cause of death?                                |
| משבו וג   | : The law re<br>cete has bee<br>, page 2 sho  | Completed        |  |  |  |  |   | 24a. Was an autopsy performe            | 24b. Were au<br>prior to death?<br>No 1 Yes    | opsy findings available ompletion of cause of 2 No |
| 0         | If othe Hospital or Attending Physician: The within 24 hours elater death.  To the Funeral Director: Affer this certificete completely filled in by the funeral director, pag   | n: To Be         | 27. Many fer of Death  | ospital: 1  Inpatient  28a. Date of Injury (Month, Day Ye                                | 2 ER/Outpatier                                     | 3 DOA  | 26. Place of Death  |   | nce 6 NOther (Spec                             | daughter'<br>residence                             |
| JUNE      | or Attendin<br>ster death.<br>Director: Afi<br>in by the fur  | ertification:    | 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury -<br>building, etc. (S  | At home, farm, str                                 | M 1  | Yes 2 □No   | 8f. Location (Stre<br>City or Town,     | eet and Number or Ru<br>State)                 | ral Route Number,                                  |
| -         | If o the Hospital or Attendi<br>within 24 hours effer death.<br>To the Funers! Director: A<br>completely filled in by the fu  | edicai Ce        | 29a. Certifier (Check only one)  | sician: To the best of m<br>ner: On the basis of exa<br>and manner stated.               | amination and/or in                                | n occurred at the ti<br>vestigation, in my o                             | me, date and place, a ppinion, death occurre                | nd due to the cau<br>d at the time, dat | use(s) and manner as<br>te and place, and due  | stated.<br>to the cause(s)                         |
| 1         | within To the comp  | Me               | 29b. Signature and title of contiller  Comparisons   | WO   |  | 29c. Licens  | se number<br>016616   | 290<br>A                                | d. Date signed (Month                          | Day, Year)   |
| 4         | 2   |                  | 30. Name and address of person who co  | mpleted cause of death<br>ARE C 94   | (Item 23a) (Type,                                  | Print)<br>NKLIN S  | OUARE D   | R. BA                                   | HIMORE,  | 2007<br>MD . 21236                                 |

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

AUG 1 4 2007

32 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |   |                | State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No. 0 7 2 5 0 7   |   |   |                       |                                       |  |   |  |  |   |  |
|---------------------|---|----------------|--|---|---|-----------------------|---------------------------------------|--|---|--|--|---|--|
| 100                 | Physici<br>/Medio   |                | Decedent's Name (First, Middle, La  Joh:   | an, Jr  | Jr.   |                       |                                       | 2. Date of Death Month Day Yea Aug 5, 2007 |   | 7  | 3. Time of Death 11:58 P <sub>M</sub>        |   |  |
|                     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland CI and Department of Health and Mental Hygiene.  Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show one marked other than "natural", or items 23a or 28a-1 show one any injury or other traumatic event, the Medical Event ner must be callined at one one.   | er             | Southern Maryland Hospital Clint  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)   If Under 1 Year   If U   |   |   |                       |                                       |  | 8. Date of Bit<br>(Month, Da  | ay, Year) Country)                                 |  |   |  |
|                     |   | Director       | 235 12 5540 TXM 2 F 85 Yrs. Worlds Days Tools June 20, 1922 West Virginia  Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits   |   |   |                       |                                       |  |   |  |  |   |  |
|                     |   |                |  | George's  |   |                       | nton                                  |  |   |  |  | 1 ☐ Yes 2 ☐ <b>X</b> No                         |  |
|                     |   |                | 10e. Street and Number 5708 Alan Driv  |   | 10f. Zip Code<br>20735  |                       |                                       |  |   | izen of What Co<br>ited Sta                        |  |   |  |
| 036                 |   | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent Ever in Agned Forces? 1. Dives 2 No If Yes, Give Year or Dates: WII  | U.S. 13.  | Was Dec<br>If Yes, sp | ecify Cuban, Me                       | nic Origin? (Spexican, Puerto              | pecify Yes or No<br>Rican, etc.)  | D-   | 14. Race - Ame<br>Black, White<br>Specify: W |   |  |
| Maryland 21215-0036 |   | Completed      | 15. Decedent's E<br>(Specify only highest gr<br>Elementary/Secondary (0-12)  | (Give   | 6a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Retired E.P.A Adminstrat: |                       |                                       |  | 16b. Kind of Business/Industry U.S. Government  |  |  |   |  |
|                     |   | To Be C        | 12 3 Retired E.P.A Adminstrative  17. Father's Name (First, Middle, Last)  John T. Ryan, Sr.  18. Mother's Name (First, Middle, Maiden Sumame)  Sybilla Eikoff   |   |   |                       |                                       |  |   |  |  |   |  |
|                     |   |                | 19a. Informant's Name/Relationship (Type, Print) Helen Ryan (Wife)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  5708 Alan Drive, Clinton, MD 20735  |   |   |                       |                                       |  |   |  |  |   |  |
| altimore,           | ages 1 a<br>ant of He<br>at: If Item<br>y or oths   |                | 20a. Method of Disposition  1  |   |   |                       | ame of other place) A                 |  | 117   |  | ington                                       |   |  |
| Baltii              | permit. F<br>Departme<br>Importar<br>any injur  |                | 4 Donation 5 Other (Specify)  Arlington National Cemetery  Arlington, VA  21. Signature of Funeral Service Literase  Arlington National Cemetery  Arlington, VA  22. Name and Address of Facility Lee Funeral Home, INc 6633 Old  Alexandria Ferry Road, Clinton, MD 20735   |   |   |                       |                                       |  |   |  |  |   |  |
| 30                  | The law requires that the death certificate be executed  The law requires that the death certificate be executed  The law requires that the death certificate and certificate | dical Examiner | 234 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of): |   |   |                       |                                       |  |   |  |  |   |  |
| P.O. Box 6          |   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)   |   |   |                       |                                       |  | 23d. Date of delivery<br>Month Day  |  |  |   |  |
| of Vita             | w requires thet the de<br>been signed by the a<br>should be detached f  | by             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |                       |                                       |  | 23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Vinknown |  |  |   |  |
|                     | r Attending Physician:<br>ler death.<br>Irsctor: After this certifics<br>h by the funeral director, i   | Completed      |  |   |   |                       |                                       |  | 24a. Was<br>auto<br>perfo   | an<br>psy<br>ormed?<br>2 3 No                      | death?                                       | topsy findings available completion of cause of |  |
|                     |   | To Be          | 25. Was case referred to medical examiner?  1 Yes 2 Oo   | Hospital: 1 Minpatient 2[   | 75000   |                       | Other                                 |  | th (Check only  |  | a []Other (0)                                |   |  |
|                     |   |                | 27. Manner of Death  Natural 5 Pending 2 Accident investigation  | 28a. Date of Injury<br>(Month, Day Year) 28b. Time of<br>Injury                       |   |                       | 28c. Injury at Work?  M 1 Yes 2 No    |  | Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred                     |  |  |   |  |
| Divis               |   | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |                       |                                       |  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)           |  |  |   |  |
|                     | To the Hospitel o<br>within 24 hours af<br>To the Funerel Di<br>completely filled in  | Medical        | 29a. Certifier 1 Certifying Pl<br>(Check only one) 2 Medical Example   | nysician: To the best of my kr<br>miner: On the basis of examin<br>and manner stated. | nowledge, dear<br>nation and/or in  | th occurre            | d at the time, da<br>n, in my opinion | ate and place,<br>n, death occur           | and due to the<br>red at the time,  | cause(s<br>date an                                 | ) and manner as<br>d place, and due          | stated.<br>to the cause(s)                      |  |
|                     | To t<br>To t  | Σ              | 29b. Signature and title of certifler  |   |   |                       | 29c. License number 28 1              |  |   | 29d. Date signed (Month, Day, Year) AUGUST 7, 2007 |  |   |  |
|                     | , , , }   | 1              | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |   |   |                       |                                       |  | 1   |  |  |   |  |
|                     | 10.   |                | Nelson Benjars,  | M.D. 6B Indu  |   | Par                   | c Drive                               | , Waldo                                    | orf, MD   | 2060   | )2   |   |  |
| 1                   | Sta<br>Registr  | _              | AUG 1 4  | 2007 32. Hegistrar's Sign   | Di da   | seed.                 | 2                                     |  |   |  |  |   |  |

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 AUGUST 8, **Physician** 8:20p M ANNIE L. RODGERS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE TOWSON GILCREST HOSPICE CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4-12-1924 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🕌 F SOUTH CAROLINA 83 218-44-1877 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ntt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f shov dical Examiner must be notified at 1√∏Yes 2□No Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21216 813 N. MONROE ST. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married BLACK 1 ☐ Yes 2 🖾 No Specify: Specify ò 3 Widowed 4 □ Divorced Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOUSKEEPING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FREDONIA THOMPSON NATHAN PONDS ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 604 STAMFORD RD. BALTIMORE. MARYLAND 21229 LaVonda ROY (GRANDDAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or ot 1 🗆 🛣 Burial 3 ☐ Removal from State LOUDON PARK 8-15-2007 BALTIMORE, MARYLAND 5 Other (Specify) 4 Donation HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immedi W Cause (Final disease or condition resulting in death) **Physician** Ischemic Endomyosathy Days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No VISCUS 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: ₄ ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Nosh( 1 ☐ Yes 2 ☐ No 3□ DOA 2 ER/Outpatient 은 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation within 24 hours after usus.

To the Funeral Director: After the funeral on the funeral or the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 6701 N. Clinks St BusIN NO AMONJ. CHAMIES, m 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

Physi /Med Exam

Funera Directo

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760%Regis DHMH 17 Rev 1/2001

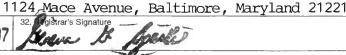
|                          | -   | For State Of Maryland / State Registrar  | -                      | ificate of L                                      |   |   | Reg. N                                 | 0.007                           | 26073  |  |
|--------------------------|---|--|------------------------|---|---|---|--|---------------------------------|--|--|
| cian                     | ı   | Decedent's Name (First, Middle, Last)  |                        |   |   | 2. Date of De<br>Month                  | ath<br>Da                              | ay Year                         | 3. Time of Death                                 |  |
| lical                    | 4   | Joseph Frank Shubra  |                        |   |   | August                                  | 10                                     | 2007                            | 12:00 P <sup>M</sup>                             |  |
| iner                     | ı   | 4a. Facility Name (If not institution, give street and number)   |                        | 4b. City, Town, or                                | Location of Death                         |   | 40                                     | c. County of Deatl              |  |  |
|                          |   | Greater Baltimore Medical Cente  |                        | Towson  |   |   |  | Baltime                         |  |  |
| l<br>r                   |   | 5. Social Security Number 6. Sex 1 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1   |                        | If Under 1 Year<br>Months Days                    | If Under 24 Hrs.<br>Hours Min.            | 8. Date of Bir<br>(Month, Da<br>June 04 | th<br>ly, <i>Year</i><br>4 <b>,</b> 19 | 9. Birth<br>Con<br>24 Alve      | nplace (State or Foreign<br>untry)<br>erton, PA. |  |
|                          | ŀ   | Usual Residence of Decedent         10b. County         10c. City, To  | own or Loca            | ation   |   |   |  |                                 | 10d, Inside City Limits                          |  |
| ioto                     |   | Maryland Baltimore County Time   | onium                  |   |   |   |  |                                 | 1 □Yes 2≹ No                                     |  |
| Funeral Director         |   | 10e. Street and Number<br>2507 Gainsford Road  |                        | 10f. Zip Code                                     | 1093                                      |   |  | itizen of What Col<br>ted Stat  | •  |  |
| uner                     |   | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?   | 13. W                  | as Decedent of Hi<br>Yes, specify Cuba            | spanic Origin? (Sp<br>n, Mexican, Puerto  | ecity Yes or No<br>Rican, etc.)         | )-                                     | 14. Race - Amer<br>Black, White |  |  |
| by F                     |   | 1 ☐ Never Married 2 ☐ Married 1 ☐ Xeres 2 ☐ No If Yes, Give Year of Dates: ₩.₩.II  | 1[                     | ⊒Yes 2.ŽANo                                       | Specify:                                  |   |  |                                 | White  |  |
| eted                     |   | 15. Decedent's Education (Specify only highest grade completed)  | 6a. Decede<br>(Give ki | nt's Usual Occupa<br>nd of work done o            | ation<br>furing most of work<br>)         | ing                                     |  | Kind of Business/I              | •  |  |
| Completed by             |   | Elementary/Secondary (0-12) College (1-4or 5+)   | life. DC               | NOT use retired,<br>Presid                        |   |   | Ca]                                    | vert Fir.<br>Compar             | re Insurance                                     |  |
| ŭ                        |   | 17. Father's Name (First, Middle, Last)  |                        | 110310  | 18. Mother's Nam                          | e (First, Middle                        | l<br>. Maide                           |                                 | ту   |  |
| To Be                    | i   | Joseph Franklin Shubra   |                        |   |   | , ,                                     |  | reminski                        | _  |  |
| -                        | 1   |  |                        |   | and Number or Rui                         |   |  |                                 |  |  |
|                          | 1   | Mrs. Dolores Marie Shubra (wife)   |                        | Gainsfo   |   |   |  | Maryland                        |  |  |
|                          |   | 4 □ Donation 5 □ Other (Specify) Evan:   |                        | tion (Name of<br>atory or other place<br>eral Cha | ,   | L2,2007                                 |  | ocation - City or<br>est Hill   | own, State<br>, Maryland                         |  |
| ž<br>N                   |   | 21. Signature of Funeral Service Ligensee  Sur, L.   | 22.<br>Pe              | Name and Addres<br>aceful A<br>325 York           | ss of Facility<br>1ternativ<br>Road       | es Fune                                 | eral                                   | &Cremati                        | on Ctr.,P.A.<br>21093                            |  |
| xaminer                  | 23a. P.11. Ent. r the chase, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, being to time additionable cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of): |  |                        |   |   |   |  |                                 |  |  |
| edical                   |   | d  |                        |   | W   |   |  | 23d. Date of deli               | verv   |  |
| hvsicial                 | 1   | in the past 12 months?  1  Yes 2 No 9 Unknown  1 Live birth 2 Fetal death 9 Unknown  |                        | ctopic pregnancy<br>Other (specify)               |   |   |  | Month                           | Day Year   |  |
| d by D                   |   | Part II. Other significant conditions contributing to death but not resulting Renul Pajkul   | ng in the und          | lerlying cause give                               | en in Part I.                             |   |  | use contribute to               | the cause of death?                              |  |
| Completed by Physician/N |   |  |                        |   |   | 24a. Was<br>auto<br>perfo               |  | death?                          | topsy findings available completion of cause of  |  |
| Be (                     |   | 25. Was case referred to medical examiner?   |                        |   | 26. Place of Deat                         | h (Check only o                         | one)                                   |                                 |  |  |
| To                       |   |  | /Outpatient            | 3□ DOA Othe                                       | er:<br>4 ☐ Nursing Ho                     | me 5 ☐ Resi                             | dence                                  | 6 ☐Other (Spec                  | cify)  |  |
|                          | 1   | 1 Natural 5 Pending (Month, Day Year)  | Bb. Time of<br>Injury  | 28c. Injun<br>Work                                |   | 28d. Describe                           | how inj                                | ury occurred                    |  |  |
| rtificati                |   | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, building, etc. (Specify)   | e, farm, stree         |   | Yes 2 □ No                                | 28f. Location (<br>City or To           | Street a<br>wn, Sta                    | and Number or Ru<br>te)         | ıral Route Number,                               |  |
| Medical Certification:   |   | 29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.   | dge, death             | occurred at the tin<br>estigation, in my o        | ne, date and place,<br>pinion, death occu | and due to the                          | cause(                                 | s) and manner as                | stated. to the cause(s)                          |  |
| Mec                      |   | 29b. Signature and title of certifier  M. Schulled   |                        | 29c. License                                      | number 44728                              | /                                       | 29d. D                                 | ate signed (Month               | h, Day, Year)                                    |  |
|                          |   | 30. Name and address of person who completed cause of death (item 3)   | ( ) (Type, Pi          | int) cuts   | 5 65                                      | 691                                     | U,                                     | Charl                           | STE 60/  |  |
| tate<br>trar             |   | 31. Date filed (Month, Day, Year)  AUG 1 4 2007  | Low                    |   | )   |   |  |                                 | 2130   |  |
|                          |   | The state of the s | 7 4                    |   |   |   |  |                                 |  |  |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 11, 2007 Schlatzer August 2:08 РМ Angela Barbara /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Middle River Ivy Hall Geriatric Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 11/10/1922 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🗆 M 186-14-1839 84 Pennsylvania **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore Middle River Funeral Director Maryland 1 ☐ Yes 2XXXVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 133 Riverthorn Road U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes **2CK**No Specify. Be Completed by Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Adolph Cibrowski Domenica Dumbrowski ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1049 Foxchase Lane, Essex, Maryland 21221 Barbara Joyce Espey (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gard: 08/13/2007 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee <u> 1407 Old Fastern Avenue, Essex, Maryland 21221</u> Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 200 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Yea 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerai Director: completely filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

State Registrar 31. Date filed (Month, Day, Year) 32. AUG 1 4 2007

Dr. John Loh, D.O.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



State Registrar

Conrad May 31. Date filed (Month, Day, Year)~

08-13-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE VAME, IO N. GREENE ST., BALTIMORE MD 21201

32. Agaistrar's Signature Blown & Sparke **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #30,perDVR,g870, 8/14/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 0619 am ) alf 2007 elber 9 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN HOSPITAL BALTIMORE N/A ocial Security Number If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **XX**M 2□F 235-26-0558 Director 3,1920 87 April West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 XYes 2 □ No Director N/A Maryland Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ō "natural", or items 23a 21234 U.S.A. 2809 Clearview Avenue Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event, the Medical Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12th. Grade Machinist Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Stewart 0die Hoyt injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie Stewart/Wife 2809 Clearview Avenue Baltimore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 08/15/2007 Gardens of Faith Cem. Baltimore MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Miller-Dippel Funeral Home, 6415 Belair Road Baltimore 21206 23a. Part1. Enter the disease, or conshock, or heart failure. Let only implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Probable Palmondro /Medical Due to (or as a consequence of): Examiner Squamous etastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent of): Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) by the a 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 1 No 3 Probably 4 Unknown 1 ☐ Yes Hupertension 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Heart Failure autopsy performed death? 2 W No 2 Da No 1∐ Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ☑ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 5 ☐ Pending investigation Injury 1 Natural within 24 hours after death.

To the Funeral Director: Af 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

31. Date filed (Month, Day, Year)

AUG 1 4

Kathleen Devore Keeffe, MD Good Samaritan Hospital Baltimore, MD

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August :00 PM Harry Roland Shriver, Jr. /Medical 200 4a. Facility Name (If not institution, give street and numb 4c. County of Death 4b. City, Town, or Location of Death Examiner HUSD. : more Minure Ci Year If Under 24 Hrs. 8. Date of Birth
Davs Hours Min. (Month, Day, Year, If Under 1 Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Months Days Director 241-44-8463 74 November 11, 1932 North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b County notified at 1 ☐ Yes 2☐ No Owings Mills 28a-f Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 3507 Coyle Road Unit 301 21117 United States of America items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates Korean 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status other traumatic event, the Medical Examiner 1 Never Married 2 Married 0 altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Communications than Elementary/Secondary (0-12) College (1-4or 5+) Radio Broadcaster WFBR WCBM 680 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Roland Shriver, Sr. Iris Dixon Pages 1 and 2 should (hanna) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry R. Shriver III 3 Ellens Choice Way, Parkton, Maryland 21120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 08/13/07 Catonsville, MD 21228 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Licenses (Moo 333 | 8728 Liberty Road, Randallstown, Maryland 21133 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. 23a. Part . Enter the dise Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown cate has been signed by page 2 should be detack 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed?

1 Yes 2 No death? this certificate funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Injury 1 Natural (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No the Hospital or Attendition 24 hours after death.

the Funeral Director: A poppletely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 💫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

AUG 1

10

D 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C (

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 30 Ernest Sullivan 13 08 2007 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Specialty Hospitel Baltimore City ) niversitu Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Dec. 29, 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Maryland 87 Dec. Director 214-16-3841 Usual Residence of Deceden or 28a-f show a notified at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 No Director MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 3 any Injury or other traumatic event, the Medical Examiner must be n 21093 USA 124 E. Padonia Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify Specify: White 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
Assistant Superintedent of Elementary/Secondary (0-12) College (1-4or 5+) Steel Manufacturing the primary mill 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie C. Powers Malcolm Worth Sullivan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi L. Sullivan/Wife 124 E. Padonia Road Timonium, MD 21093 20b. Place of Disposition (Name of Dulaney Valley 20a, Method of Disposition 20c. Location - City or Town, State Aug. 14 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Memorial Gardens 2007 Timonium, MD 22. Name and Address of Facility Home of Dulaney Valley, Inc. Signature of Fu Michael J. Flagle 10 W. Padonia Road Timonium, MD 21093 23a. Part1 Enter the disease shock, or heart failure. encolor complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition CERTIFICATION APPROVED BY MEDICAL EXAMINATE resulting in death) /Medical Due to (or as a consequence of) **Examiner** piration Oneumonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit the death certificate be executed Due to (or as a consequence of) Les P.O. Box 68760 attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No een signed by the 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an te has autopsy perform 1 ☐ Yes 2 XNo 1□ Yes 2▼No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Driver lost 27. Manner of Death 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural consciousness, con drove off rond, 1225A 1 ☐ Yes 2 XNo 06-02-2007 2 Accident rolled 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Street

Raleigh-Durham, MC

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

140,

State Registrar 31. Date filed (Month, Day, Year)

AUG 1

4

29b. Signature and title of certifier

MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

MD

601

29c. License number

D0061882

S. Charles St.

29d. Date signed (Month, Day, Year)

08-13-2007

Baltimore MD 21230

|                 |  |               | 1 - For State of Maryla   |                                    | artment of He  |                             |  | ene 0 0 7                        | 26079   |
|-----------------|--|---------------|---|------------------------------------|--|-----------------------------|--|----------------------------------|---|
|                 | 40° H  |               | Decedent's Name (First, Middle, Last)   |                                    |  |                             | 2. Date of Death                       | 1                                | 3. Time of Death  |
|                 | Physici<br>/Medic  |               | Constance June Stone  |                                    |  |                             | Aug 9, 2                               | Day Yea<br>2007                  | 1:10 A M  |
|                 | Examin   |               | 4a. Facility Name (If not institution, give street and number)  |                                    | 4b. City, Town, or L   | ocation of Death            |  | 4c. County of De                 |   |
|                 |  |               | Cherry Lane Nursing Cen   |                                    | Laurel If Under 1 Year   | If Under 24 Hrs.            | O Data of Dist                         | Prince (                         |   |
|                 | Funeral Director   | 5             | 1 □ M 2 □ F   | s. last birthday)<br>Yrs.          | Months Days  | Hours Min.                  | 8. Date of Birth (Month, Day, June 11. | Year) (                          | irthplace (State or Foreign<br>Country)<br>ashington DC |
|                 | α.   |               | 577 32 7473 X 80 Usual Residence of Decedent  |                                    |  |                             | Julie 11,                              | 1921 W                           | ashington DC  |
|                 | nylan<br>show  | L.,           |   | City, Town or Lo                   | ocation  |                             |  |                                  | 10d. Inside City Limits                                 |
|                 | 89-f   | Director      | Maryland   Prince George's  | Laurel                             |  |                             |  |                                  | 1 Yes 2 No  |
|                 | with the sor 2 be n  |               | 10e. Street and Number<br>9001 Cherry Lane  |                                    | 10f. Zip Code  | 0708                        | 10                                     | g. Citizen of What (<br>United : | •   |
|                 | ns 23  | eral          | 11. Marital Status 12. Was Decedent Ever in   | U.S. 13.                           |  |                             | ecify Yes or No-                       |                                  | nerican Indian,   |
| 36              | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 is marked other than "natural", or Items 23a or 28e-f ehow or other treumatic event, the Madical Examinar must be mutilised at | by Funeral    | Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:   |                                    | Was Decedent of His<br>If Yes, specify Cuban<br>1 ☐ Yes 2 <b>XX</b> No | Mexican, Puerto<br>Specify: | Rican, etc.)                           | Black, W!                        |   |
| 9500-61212      | 2 hou<br>atura   | ted           | 15. Decedent's Education  |                                    | dent's Usual Occupat   |                             | . 1                                    | 6b. Kind of Busines              | :s/Industry   |
| Z               | thin 7<br>8.<br>an "n<br>Mad   | Completed     | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  | life.                              | kind of work done du<br>DO NOT use retired)                            | iring most of work          | ing                                    |                                  |   |
|                 | filed will<br>Hygien<br>other th   | Con           | 10  | Ko                                 | dak Film I   |                             |  | Kodak (                          | Corp  |
| חמ              | be file<br>d oth   | Be            | 17. Father's Name (First, Middle, Last) Russell T. Kite   |                                    | 1  |                             | e (First, Middle, M<br>Mae Doval       |                                  |   |
| Maryiand        | 2 should be f<br>and Mental H<br>Is marked of<br>reumatic eve  | 2             |   | 10h 14-11                          | Add (C+  |                             |  |                                  | 7in Contol  |
|                 | 1 and 2 st<br>Health and<br>Iom 27 Is n  |               | 19a. Informant's Name/Relationship (Type, Print) Linda Duffus (Daughter)  |                                    | ng Address (Street ar.<br>Sunrise Ro                                   |                             |  |                                  |   |
| e,              | of He<br>of He<br>fitem  |               | 20a. Method of Disposition 20b 1X Burial 2 Cremation 3 Removal from State   | . Place of Dispo<br>cemetery, crei | sition (Name of<br>matory or other place)                              | Aug 22,                     | <sup>Date</sup> 2007 <sup>2</sup>      | Oc. Location - City              | or Town, State  |
| Ĕ               | Pag<br>ment<br>ent: I<br>ury o   |               | 4 Donation 5 Other (Specify)  |                                    | National   |                             |  |                                  | , Virginia  |
| baitimore,      | permit. Pages 1 an<br>Department of Heal<br>Importent: If Item 2<br>any Injury or other<br>once.   |               | 21. Signature of Funeral Service Licensee  MULTO D. DULY  MOIZ  | - 1   -                            | 2. Name and Address<br>exandria I                                      |                             |  | •                                | 663301d<br>20735  |
| b               | 6 6 2 34   | 33            | 23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. | ath. Do not ent                    | er the mode of dying,  | such as cardiac o           | or respiratory arre                    | st,                              | Approximate<br>Interval Between                         |
|                 | Physician  |               | Immediate Cause (Final disease or condition Metasta   | tic                                | Lung (   | Cancer                      | _                                      |                                  | Onset and Death  1ear)                                  |
|                 | /Medical<br>Examiner   |               | resulting in death)  Due to (or as a cons   | equence of):                       |  |                             | <del></del>                            |                                  | 1   |
|                 | A State  | <u></u>       | Sequentially list conditions, if any, leading to immediate b. Due to (or as a cons  | equence of):                       |  |                             |  |                                  |   |
| ۸.              | ted<br>nsit  | Examine       | cause. Enter Underlying<br>Cause (Disease or injury   | equalica oi).                      |  |                             |  |                                  |   |
| <i>ŋ</i> .      | execunate and all-tra  | Exar          | that initiated events c   | equence of):                       |  |                             |  |                                  |   |
| 9/90            | cate be executed<br>physicien and<br>the burial-transit  | dlcai         | d   |                                    |  |                             |  |                                  |   |
| ٥               | ing ph   | Med           | IF FEMALE:  |                                    |  |                             |  |                                  |   |
| X<br>D<br>D     | death certific<br>e attending p<br>id for use es   | Iclan/Me      | 23b. Was decedent pregnant in the past 12 months?   | etal death 3                       | Ectopic pregnancy  |                             |  | 23d. Date of o                   | lelivery<br>Day Year                                    |
| o<br>o          | the a  | hysic         | 1 ☐ Yes XX No 4 ☐ Pregnant at time of 9 ☐ Unknown 9 ☐ Unknown   | ideath 5                           | Other (specify)  |                             |  |                                  | ,   |
| 7               | that the ed by detac   | α.            | Part II. Other significant conditions contributing to death but not re  | esulting in the u                  | nderlying cause given  | in Part I.                  | 23e. Did tob                           | acco use contribute              | to the cause of death?                                  |
| as,             | w requires that the death certific<br>been signed by the attending p<br>should be detached for use es  | d by          |   |                                    |  |                             | 1 ☐ Ye                                 | s 2 No 3                         | Probably 4 Dinknown                                     |
| Cora            | taw rec<br>as beer<br>2 shou   | ompleted      |   |                                    |  |                             | 24a. Was ar                            | 24b. Were                        | autopsy findings available                              |
| Ĭ.              | 0 5  | mo            |   |                                    |  |                             | autopsy perform                        | prior t<br>death<br>DNo 1 Y      |   |
| VII             | icien: Th<br>certificate<br>rector, pag  | BeC           | 25. Was case referred to medical  |                                    |  | 26. Place of Deatl          | h (Check only one                      | -                                | 55 E VE 110   |
| ><br> <br> <br> | d o  | ToE           | examiner?  1 Yes 2 No Hospital: 1 Inpatient 2   | ☐ ER/Outpatier                     | nt 3 DOA Other   | ▼ Nursing Ho                | me 5 Reside                            | nce 6 Other (S)                  | pecify)   |
|                 | ing<br>ine   | :uo           | 27. Manyfer of Death 28a. Date of Injury 1 √ Natural 5 □ Pending (Month, Day Year)  | 28b. Time o<br>Injury              | Work?  |                             | 28d. Describe ha                       | w injury occurred                |   |
| Sign            | death<br>tor: /<br>the f   | cat           | 2 Accident investigation 3 Suicide 6 Could not be 290 Place of Injury.  | hama farm at                       |  | es 2 No                     | 29t Location /Cts                      | ant and Number or                | Qual Route Mumber                                       |
| UNISION         | el or Attending F<br>s after death.<br>I Director: After<br>d in by the funer  | ertification: | 4 Homicide determined 28e. Place of Injury - At building, etc. (Spe   | cify)                              | eet, factory, office   |                             | City or Town                           |                                  | Rural Route Number,                                     |
|                 | To the Hospitel or Attending Ph<br>within 24 hours after death.<br>To the Funerel Director: After th<br>completely filled in by the funeral  | alc           | 29a. Certifier 1 Certifying Physician: To the best of my k  | nowledge, deat                     | h occurred at the time   | , date and place,           | and due to the ca                      | use(s) and manner                | as stated.  |
|                 | the Hoin 24<br>the Fu  | ledical       | (Check only 2 Medical Examiner: On the basis of examiner and manner stated.   | nation and/or in                   |  |                             |  |                                  |   |
|                 | with To To   | Σ             | 29b. Signature and title of certifier   |                                    | 29c. License   |                             | -                                      | d. Date signed (Mo               |   |
|                 |  |               | the very  | 4)                                 |  | 1051                        | /                                      | Luguit                           | 10, 2007  |
|                 | 12   |               | 30. Name and address of person who completed cause of death (II Andres Salazar, M.D. 3621 Lig                                 |                                    |  | t City N                    | MD 21በሉ2                               | ~                                |   |
| All .           | Sta  | te            | 31. Date filed (Month, Day, Year)  AUG 1 4 2007   | nature                             | all D  |                             | 1074                                   |                                  |   |
| -               | Registr  | ar            | AUG 1 4 2007  | 10. 140                            |  |                             |  |                                  |   |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 3. Time of Death 4 Day Month **Physician** 2007ª 8 P M 1:03 John Paul Simms /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Talbot Easton Talbot Hospice Foundation 8. Date of Birth (Month, Day, 6/1/1917 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 X M 2 □ F 218-18-4972 90 Baltimore, MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show 1 XYes 2 No MD Talbot Easton Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e USA 21601 "natural", or Items 23a 29814 Dustin Ave. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23, and ver other traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1943-47 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cabinet Maker **Furniture** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Maconis John Ambrose Simms ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Langnack / Niece 29814 Dustin Ave. Easton, Maryland 21601 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 8/7/2007 Holv Redeemer Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 adu Approximate Interval Between Onset and Death UNS. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final DISZASE CHRENIC BRSTRUCTIVE PLILMONARY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dee to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea: 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MY ELO DUSPCASIC 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Matural 2 ☐ Accident 5 Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No

or Attending Physician: The law requires that the death certificate be executed physician and sthe burial-tr Division or Vital Records, P.O. Box 68760, attending | signed by the a this After

the Maryland

with

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director: ,
completely filled in by the f To the Hospital

State

Medical Certification: To

REBOR 31. Date filed (Month, Day, Year)

29b. Signature and little of certifier

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

6 Could not be determined

allum mis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATTERSON

29c. License number D0057908

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 01

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ST MICHARUS MAD

32. Refistrar's Signature R. Alle

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

800 S. PARANT ST

| lores Sagendo   |               | St<br>I- For State  | ate of Maryla         | and / Depai                    | rtment of         |                         | and                  | Menta                     | al Hygie                    |                        | (                | .00         | 1              | 2608                                 |
|---|---------------|---|-----------------------|--------------------------------|-------------------|-------------------------|----------------------|---------------------------|-----------------------------|------------------------|------------------|-------------|----------------|--------------------------------------|
| DI  | F             | Registrar  1. Decedent's Name (First, Midd                        | e last)               |                                | inoute or         | Dodin                   |                      |                           | 2. D                        | ate of Death           | g. No.           |             | 3. Time        | e of Death                           |
| Physicia<br>edical Exami  | ner           | Dolores Sagen   | dorph                 |                                |                   |                         |                      |                           |                             | onth<br>ugust 2, 2     | Day Y<br>2007    | 'ear        |                | 35 hrs                               |
|   |               | 4a. Facility Name (if not institution 524 North Charles Str       |                       | imber)                         | 41                | b. City, Tov<br>Baltimo |                      | ocation of I              | Death                       |                        | 4c. Count        | ty of Deat  | th             |                                      |
|   |               |   | 6. Sex                | 7. Age (In yrs. Ia             | et hirthday)      | If Under                |                      | If Under 2                | 24Hrs. 18.                  | Date of Birt           | h(MM/DD/YY       | YY) 9. Bi   | irthplace      | (State or                            |
| Funeral<br>Director   |               | 5. Social Security Number 172–22–1822                             | 1 M 2 X F             | 7. Ago (iii yio. ia            | 78 Yrs.           | Months                  |                      | Hours                     | Min                         | ct 4,                  |                  | Fore        | ign<br>ountry) | PA                                   |
|   | ŀ             | Usual Residence of Decedent                                       | 1 M 221 F             |                                | / 0 115.          | <u> </u>                |                      | _                         | 10                          | ,,,                    | 1720             |             |                |                                      |
| any.  |               | 10a. State 10b. County  |                       | 10c. City,                     | Town or Location  | on                      |                      |                           |                             |                        |                  |             |                | nside City Limits                    |
| *   | ٦             | MD  |                       |                                | Balt              | imore                   |                      |                           |                             | 201                    |                  |             |                | Yes 2 No                             |
| laryla<br>28a-f   | Director      | 10e. Street and Number  |                       |                                |                   | 10f. Zip C              |                      |                           |                             | 10                     | g. Citizen of    |             | untry?         |                                      |
| , MD 21215-0036 sand 2 should be filed within 72 hours after death with the Maryland honel Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once. |               | 524 N. Charle   | 1.00                  |                                |                   |                         |                      | 21201                     | _                           |                        |                  | SA          |                | . Dit-                               |
| h with  | Funeral       | 11. Walta Olatos  | 12. Was De<br>Armed F | cedent Ever in U.:<br>orces?   | S. 13. Was        | Decedent<br>es, specify | of Hispa<br>Cuban, I | anic Origir<br>Mexican, F | n? ( Specify<br>Puerto Rica | Yes or No<br>an, etc.) | 14. Ra           | hite, etc.  | erican ind     | tian, Black,                         |
| r deat<br>or ite  | 핕             |   | 1 Yes                 | 2 X No                         |                   | Yes 2 X                 | No                   | specify.                  |                             |                        | Specif           | fv:         | whit           | e.                                   |
| rs afte<br>ural",   | Ď             | Widowed 4 Di  | l or Dates:           |                                | 16a. Decedent     |                         |                      |                           | nd of work                  | done                   | 16b. Kind of     |             |                |                                      |
| 2 hour  | ted           | Elementary/Secondary (0-12)                                       |                       | 1-4 or 5+)                     | during mo         | ost of worki            | ng life. [           | OO NOT u                  | ise retired)                |                        | **               |             |                | 3460 101 10                          |
| 21215-0036 unld be filed within 7 Mental Hygiene. marked other than ic event, the Medica  | Completed     | 12  |                       | 0                              | te1               | ephor                   |                      |                           |                             |                        |                  |             | unic           | ations                               |
| 5-0(<br>ed wi<br>tygier<br>other  | S             | 17. Father's Name (First, Middle                                  | , Last)               |                                |                   |                         | 18                   |                           |                             |                        | Maiden Surna     | me)         |                |                                      |
| 21;<br>be fill<br>antal I-<br>rent, 1   | Be            | Earl Vincent  |                       |                                |                   |                         |                      |                           |                             | Sinnot                 | nber, City or T  | Forum Cto   | to Zin C       | odo)                                 |
| 221<br>should<br>nd Me<br>is ma   | ို            | 19a. Informant's Name/Relation                                    |                       |                                | 1                 |                         |                      |                           |                             | se, CA                 |                  |             | ite, zip C     | 008)                                 |
| ME 27   |               | Longly Sagend 20a. Method of Disposition                          | orpn/son              | 20b. F                         | Place of Disposi  |                         |                      |                           |                             | ate Or.                | 20c. Location    |             | or Town,       | State                                |
| Ore,<br>ses 1 a<br>of He<br>If ite  |               | 1 Burial 2 Crematic   | n 3 Removal           |                                | crematory or oth  |                         |                      |                           |                             |                        |                  |             |                |                                      |
| Baltimore, MD pernit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati  |               | 4 Donation 5 X Other S  | Specify: in/st        | ate                            | €2. N             | lame and A              | ddress :             | of Facility               |                             | 55 1.1                 | Balti            | more        | Str            | enet .                               |
| Baltimore, MD 21215-0036  peperit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Montal Hygiene, Infine 77 is marked other than "natural", injury or other traumatic event, the Medical Examiner.      |               | 21. Signature of Fig. al Service                                  | Stile Warde,          | Director                       |                   | lte Ar                  |                      |                           | 21201                       |                        | Dalti            | LIIIO I E   | ניטנו          | . 661                                |
| Physician   | _             | 23a. Part I. Enter the disease, of                                | r complications that  | caused the death               | . Do not enter th | ne mode of              | dying, s             | such as ca                | ardiac or res               | spiratory arr          | est, shock, or   | r heart     |                | proximate Interval                   |
| M dical   | 6 1           | hailure. List only one caus                                       | Athennesol            | erotic Cardiov                 | ascular Dis       | ease                    |                      |                           |                             |                        |                  |             |                | Death                                |
| xaminer   |               | or condition resulting in death)                                  |                       | a consequence o                |                   |                         |                      |                           |                             |                        |                  |             |                |                                      |
|   | <u>_</u>      | Sequentially list conditions, if any, leading to immediate        | b. Due to (or as      | a consequence o                | of);              | _                       |                      |                           |                             |                        |                  |             |                |                                      |
|   | n<br>L        | cause. Enter Underlying Caus<br>(Disease or injury that initiated | c                     |                                |                   |                         |                      |                           |                             |                        |                  |             |                |                                      |
| cuted<br>nd<br>transit  | Examiner      | events resulting in death) Last                                   | Due to (or as         | a consequence o                | ot):              |                         |                      |                           |                             |                        |                  |             |                |                                      |
| re executed<br>cian and<br>rial - trans   | dical         | UNPENDED  | AMENDE                | )                              |                   |                         |                      |                           |                             |                        |                  |             |                |                                      |
| ' <b>60</b> , ate be  | Med           | IF FEMALE:  |                       | s, outcome of preg             | nancy             |                         | c) —                 |                           |                             | _                      |                  | te of deliv |                | Vaar                                 |
| ox 68760, eath certificate be attending physic for use as the bur   | Physician/Me  | 23b. Was decedent pregnant in past 12 months?                     | ,                     | e birth<br>gnant at time of de |                   | etal death              | 3                    | Ectopic                   | pregnancy                   | /                      | Mont             | th          | Day            | Year                                 |
| Box e death contract the atten  | ysic          | 1 Yes 2 No 9 🗸 U  | -len ouen             | nown                           | 5 O               | ther (Spec              | .ny)                 |                           |                             |                        | 1                |             |                |                                      |
| हेर्द में   |               | Part II. Other significant cond                                   | itions contributing   | to death but not i             | resulting in the  | underlying              | cause g              | iven in Pa                | ırt I.                      | -                      |                  |             |                | ause of death?                       |
| , P.O<br>ires that t<br>signed by   | d by          |   |                       |                                |                   |                         |                      |                           |                             | 1 Ye                   |                  |             |                | 4 Unknown                            |
| Records, The law require ficate has been si, page 2 should t  | Completed     |   |                       |                                |                   |                         |                      |                           |                             | 24a. Was               | psy              | prior       | to comple      | findings available etion of cause of |
| tal Reco  | ᄩ             |   |                       | <u> </u>                       |                   |                         |                      |                           |                             |                        | ormed?<br>2 ✔ No | death<br>1  | Yes            | 2 No                                 |
| Vital Rec<br>ysician: The l<br>his certificate l<br>director, page  | Ü             | 25. Was case referred to medic                                    |                       |                                |                   | 2                       | 6.Place              |                           | (Check on                   | y one)                 |                  |             |                |                                      |
| Vita<br>nysicia<br>I direc  | , B           | examiner?<br>1 ✓ Yes 2 No   | Hospital: 1           | Inpatient 2                    | ER/Outpatien      |                         | OA                   | Other <sub>4</sub>        | Nursing 1                   |                        | Residence        |             | ther: Sce      | ne                                   |
| n of ing Ph<br>After (funeral   | Ë             | 27. Manner of Death  1 Natural 5                                  | (Mo                   | te of Injury<br>nth, Day,Year) | 28b. Time of      | Injury 2                |                      | ry at Work<br>res 2       | - 1                         | sa. Describe           | how injury o     | ccureu      |                |                                      |
| Sior<br>strend<br>death.<br>ctor:   | ĕ             | 0 16  | nding<br>restigation  | ace of Injury - At h           | ome form stre     | ot factory              |                      |                           |                             | Rf. Location           | (Street and N    | lumber or   | Rural Ro       | oute Number, City                    |
| Division of Vital ral or Attending Physician: rs after death. al Director: After this certiled in by the funeral director   | ertification: | de  | termined (Speci       |                                | ione, iann, suc   | oci, raciory            | , onice b            | anding, or                |                             | or Town,               |                  |             |                |                                      |
| Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the   | U             | 4 Homicide  | Physician: To the I   |                                | dge, death occu   | irred at the            | time, da             | ate and pla               | ace, and du                 | ue to the car          | use(s) and ma    | anner as    | stated.        |                                      |
| the H<br>the F<br>the F   | Medical       | (Check only one) 2 Medical E                                      | caminer: On the bas   | is of examination              | and/or investiga  | ation, in my            | opinion              | , death oc                | curred at the               | ne time, dat           | e and place, a   | and due t   | o the cau      | use(s)                               |
| To To   | Me            | 29b. Signature and title of cert                                  |                       | // N                           |                   | 290                     | . Licens             | e number                  |                             |                        | 29d. Date        |             |                | Day, Year)                           |
|   |               | Milino  | bracell               | MA                             | -                 |                         | O.C.                 | M.E.                      |                             |                        | August           | 3, 200      | 7              |                                      |
|   |               | 30. Name and address of pers                                      |                       |                                |                   |                         |                      | ) = 14°                   | - 140.0                     | 1201                   |                  |             |                |                                      |
|   |               | Melissa Brassell, Mi  |                       | Medical Exam                   |                   | Penn St                 | reet, E              | saltimor                  | e, MD 2                     | 1201                   |                  |             |                |                                      |
|   | State         | Z11115 F  | 4 2007 32             | Registrar's Signa              | ruje              | SACCE                   |                      |                           |                             |                        |                  |             |                |                                      |

State of Maryland / Department of Health and Mental Hygiene [] For State Registrar 1-Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** mmon 14 2007 /Medical Facility Name (If not institution, give street and number) Bulfimore 4b. City, Town, or Location of Death Randalls fown Examiner 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 CA 6. Sex 1⊠M 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9–29–1934 **Funeral** Days Hours Min. 215-30-8149 GA Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show th and Mental Hygiene. 17 is marked other than "natural", or lieme 23s or 28s-1 shov traumatic event, the Medical Examilmer sussible notified at Baltimore Randallstown MD 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8629 Lucerne Road 21133 USA Funerai Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1∆ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: African-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced American 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Truck Driver 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Ammie Lee Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Depertment of Health ar Important: If Item 27 is any injury or other trau 8629 Lucerne Rd., Randallstown, MD 21133 Audrey F. Simmons/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removal from State 8-16-07 Owings Mills, MD Garrison Forest Vet. 4 □ Dopation 5 □ Other (Specify) Standare of Funeral Service Licenses 22. Name and Address of Facility Wile F/ H P.A. of Balto. Co. 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiovaseva **Physician** Atherosc /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner hed by the attending physicien and detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☑ Únknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 No 1 ☐ Yes : After this certifications a funeral director. 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2XER/Outpatient 3□ DOA ၉ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident I Director: A 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 🗌 Homicide 29a. Certifier TCCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 0036819 Northwest Hospital Center me, and address of person who completed cause of death (Item 23a) (Type, Print) XI W a Tricia 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Marc & AUG 1 4 2007 DHMH 17 Rev 1/2001

ORIGINAL

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician: ours after death.

neral Director: A
filled in by the fu within 24 hours a

Registrar

Year) 31. Date filed (Month, Day,

29a. Certifier (Check only one)

29b. Signature and title of certifier



29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHILADEEPHYA: ROAD - ROSEDALE, MD 21237 HOWARD GOLDMAN -9106

32 Registrar's Signature

State

# **Physician** /Medical Examiner **Funeral** Director "natural", or items 23a or 28a-f show edical Ex miner must be notified at Directo Funeral þ

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) ISABEL SAVANUCK AUGUST 11 7:20 P M 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3423 MANOR HILL ROAD BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Months 121-10-9089 1 □ M 2 😿 F 86 07/16/1921 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐Yes 2 ☐ No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3423 MANOR HILL ROAD 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No WHITE Specify 3 X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ HOMEMAKER permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other tt any injury or other traumatic event, the once. OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **KORNSPUN** ABRAHAM SARAH ROSENFELD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3423 MANOR HILL ROAD - BALTIMORE, MD 21208 STUART SAVANUCK / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Decation 5 ☐ Other (Specify) BALTIMORE HEBREW CONG 08/13/2007 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Se. ide Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 enuso P tal. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, P bt1 Enter the Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) by the a 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Q 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s autop-performe certificate 1☐ Yes Director: After this certific in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home Specification 6 Other (Specify) 1 ☐ Yes 2 No ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the ...
within 24 hours after
To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certife 29d. Date signed (Month, Day, Year) 30. Name and address of pers cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State AUG 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Division or Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene/ Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician рΜ ADELAIDE SILBERSTEIN AUGUST 2007 3:50 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BROADMEAD RETIREMENT COMMUNITY HUNT VALLEY BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/11/1904 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Director 212-36-8521 103 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State iral, or items 23a or 28a-f show Examiner must be notified at 10b. County 1 ☐ Yes 2 🛛 No Director MD BALTIMORE HUNT VALLEY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13801 YORK ROAD U.S.A. 21030 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE Baltimore, Maryland 21215-0036 Specify: 3 Nidowed 4 □ Divorced "natural" al Hygiene. d other then "natura went, IL e Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME it of Health and Mental Hyg if item 27 is marked othe or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be ROSENSTOCK JACOB NETTI BROFMAN ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 HIDDEN WOOD COURT - BALTIMORE, MD 21208 SALLY WEINMAN / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pege Department important: If sny injury or \* 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CONG. 08/16/2007 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature/pf Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part / Enter/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, it any, bading to incrediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner buriaj-translt Due to (or as a consequence of) Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 3 Probably 4 Unknown Record Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 1 Yes tai Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Certification: To 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ō 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Division 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: # 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitei or The ortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai within 24 29b. Signature and title address of person who compared cause of death (Item 23a) (Type, Print) YORK RD, COCKEYSUILE MD, 21030 3801

DHMH 17 Rev 1/2001

State Registrar

32 Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                     |  | 1                | For State Registrar  |  |                       | tificate of L   |  |                                 | Reg. No.         |                         | 26085   |
|---------------------|--|------------------|--|--|-----------------------|---|--|---------------------------------|------------------|-------------------------|---|
|                     | Physicia   | n                | I. Decedent's Name (First, Middle, Last)   | -  |                       |   |  | 2, Date of Dea<br>Month         | Day              | Year                    | 3. Time of Death                                |
|                     | /Medic   | al .             | Agnes Louise Thompson  |  |                       | th Oil Town   | Leasting of Death                      | August                          |                  | 007<br>by of Death      | 10:15 P <sup>M</sup>                            |
|                     | Examin   | er               | I. racii on a f. Tanayyt arm   | imber)   |                       | _   | Location of Death                      |                                 | Carr             |                         |   |
| <del>f.c.v.</del>   | ** <u>-</u>  |                  | Lorien of Taneytown  S. Social Security Number 6. Sex  | 7. Age (In yrs. Ia   | ast birthday)         | Taneytow<br>If Under 1 Year                                     | If Under 24 Hrs.                       | 8. Date of Birt                 | h                | 9. Birth                | place (State or Foreign                         |
|                     | Funeral<br>Director  |                  | 216-03-5803 <sup>1□ M 2</sup> F  | 87   | Yrs.                  | Months Days   | Hours Min.                             | NOV 15                          | , 1919_          | Mar                     | yland   |
|                     | aryland<br>show<br>dat   |                  | Usual Residence of Decedent 10a. State 10b. County   |  | , Town or Lo          |   |  |                                 |                  |                         | 10d. Inside City Limits<br>1                    |
|                     | the M<br>28a-f<br>otifie   | ectc             | MD Carrol1   | Tai  | neytow                | 10f. Zip Code   |  |                                 | 10g. Citizen of  | What Cou                | ntry?   |
|                     | 3a or 3  | Funeral Director | 100 Antrim Blvd, Room 6  |  |                       | 21787   |  |                                 | USA              |                         |   |
|                     | death  | ner              | 11. Marital Status 12. Was De  | cedent Ever in U.S   | S. 13.                | Was Decedent of Hi<br>If Yes, specify Cuba                      | ispanic Origin? (Span, Mexican, Puerto | ecify Yes or No<br>Rican, etc.) | - 14. Ra<br>Bla  | ace - Americack, White, |   |
| Maryland 21215-0036 | 172 hours after death with the Maryland<br>"natural", or Items 23a or 28a-f show<br>edical Examiner must be notified at  | by               | 1 □ Never Married 2 □ Married 1 □ Yes<br>3 🖁 Widowed 4 □ Divorced 1 □ Yes, C<br>Year or  | 2XMNo<br>ive   |                       | 1 □ Yes 2 X No  | Specify:                               |                                 | Spec             | Whi                     | ite   |
| ည                   | 72 ho<br>'natur  | etec             | 15. Decedent's Education<br>(Specify only highest grade completed  | )  | 16a. Deced<br>(Give   | dent's Usual Occup<br>kind of work done o<br>DO NOT use retired | ation<br>during most of work           | ing                             | 16b. Kind of I   | 3usiness/Ir             | ndustry   |
| 7                   | be filed within 72 ho<br>ttal Hygiene.<br>d other than "natui<br>event, the Medical  | Completed        | Elementary/Secondary (0-12) College  | (1-4or 5+)   | Cler                  |   | "                                      |                                 | Lock &           | Kev                     | Supply  |
| N                   | e filed v<br>Il Hygie<br>other i   | ပ္သ              | 17. Father's Name (First, Middle, Last)  |  | OICL                  |   | 18. Mother's Name                      | e (First, Middle,               |                  |                         | υάρριγ  |
| an                  | ld be<br>ental<br>ked o  | To Be            | Bernice Saunders Blake   |  |                       |   | Agnes Ros                              | se Hear                         | า                |                         |   |
| <u></u>             | should and Men<br>s marker   | ۴                | 19a. Informant's Name/Relationship (Type. Print)   |  | 19b. Mailir           | ng Address (Street  |  |                                 |                  | n, State, Zi            | p Code)   |
|                     | is 1 and 2 should by Health and Meni<br>item 27 is marked<br>other traumatic   |                  | Sharon E. Long/Daughter  |  |                       | Our Way L   |  |                                 |                  |                         |   |
| e<br>O              | 0 - <del>-</del> -   |                  | 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from  |  |                       | osition (Name of<br>matory or other plac                        |  | Date                            | 20c. Location    | - City or T             | own, State                                      |
| Ĕ                   | Pages<br>ment of<br>ant; If its<br>ury or o  |                  | 4 □ Donation 5 □ Other (Specify)   | Met  | tro Cr                | ematory,  | Inc 8/10,                              | /07                             | Baltim           |                         | MD  |
| Baitimore,          | permit. Pag<br>Department<br>Important: I<br>any Injury o  |                  | 21. Signature of Funeral Service Licensee C.   | odd Drin   | ng 🧗 Ĉ                | 2. Name and Addre   | ss of Facility<br>Society_o            | of Mary                         | land, I          | nc.                     |   |
|                     | 20280  |                  | 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one can e or   | caused the death   | 12                    | 99 Freder   | nck Rd Ba                              | altimore                        | ≥. MD 2.         | 1228                    | Approximate<br>Interval Between                 |
|                     |  | V 10             | shock, or heart failure. List only one cause on<br>Immediate Cause (Final  | · ·  |                       | 1 -   | ,                                      | 9                               |                  |                         | Onset and Death                                 |
|                     | Physician<br>/Medical  |                  | disease or condition   | o (or as a consequ   | uence of):            | un a  | caste                                  | m O:                            |                  | _                       | 4 Car   |
|                     | Examiner   |                  | a  | sterio   | rele                  | rate 1  | arente                                 | ~ New                           | las              |                         | 2542  |
|                     | # 14-to  | ē                | Sequentially list conditions, if any, leading to immediate  Due to the conditions of | o (or as a consequ   | uence of):            |   |  |                                 |                  |                         | 1   |
| V                   | cuted<br>nd<br>ransit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.   |  |                       |   |  |                                 |                  |                         |   |
| 20,                 | ifficate be executed<br>g physician and<br>as the burial-transit   |                  | resulting in death) Last Due t   | o (or as a consequ   | uence of):            |   |  |                                 |                  |                         |   |
| 68760,              | cate t<br>physic<br>the k  | edical           | d  |  |                       |   |  |                                 |                  | - 3                     |   |
| Вох                 | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burat-transit                      | Physician/Me     | 23b. was decedent pregnant   | outcome pf pregna<br>birth 2 ☐ Feta<br>gnant at time of d<br>known | Ideath 3              | ⊒Ectopic pregnanc<br>⊒ Other (specify) _                        | у                                      |                                 |                  | Date of deli            | very<br>Day Year                                |
| P.O.                | that the ed by detac   | / Ph             | Part II. Other significant conditions contributing to  | death but not res  | ulting in the L       | underlying cause giv  | en in Part I.                          | 23e. Did                        | tobacco use co   | ontribute to            | the cause of death?                             |
| ds                  | quires<br>n sign<br>lld be   | d by             |  |  |                       |   |  | 1 🗆                             | Yes 2⊡No         | 3 □ Pro                 | obably 4 □Unknown                               |
| Records,            | w requir<br>s been si<br>s should I  | Completed        |  |  |                       |   |  | 24a. Was                        |                  | b. Were au              | topsy findings available completion of cause of |
| æ                   | The la<br>te has   | шo               |  |  |                       |   |  | auto<br>perf<br>1  Yes          | ormed?           | death?<br>1 ☐ Yes       |   |
| Vital               | an:<br>rtifical<br>tor, p  | Be C             | 25. Was case referred to medical   |  |                       |   | 26. Place of Dea                       |                                 |                  |                         |   |
| <u>-</u>            | nysici<br>nis ce<br>direc  | To E             | examiner?  1 Yes 2 No  Hospital: 1   | ☐Inpatient 2☐  |                       | III 3 DOA   |  | ome 5 Res                       |                  |                         | cify)   |
| 0                   | ng Pt<br>ifter th  | Ë                | 1 ☐ Natural 5 ☐ Pending (M   | te of Injury<br>onth, Day Year)                                    | 28b. Time o<br>Injury | Wo  |  | 28d. Describe                   | how injury occ   | urred                   |   |
| Sio                 | tendi<br>eath.<br>tor: A<br>the fu   | cati             | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. Pla   | as of injury. At h   | omo farm si           | M 1 □<br>treet, factory, office                                 | ]Yes 2□No                              | 28f Location                    | (Street and Nu   | mber or Ri              | ıral Route Number,                              |
| Division or         | or At<br>after d<br>Direc<br>in by   | Certification:   |  | lding, etc. (Specif  | fy)                   | reet, factory, office   |  | City or To                      | wn, State)       | 7,50, 0, 110            |   |
|                     | spital<br>ours<br>ours<br>reral  |                  | 29a. Certifier 1 Certifying Physician: To  | he best of my kno  | owledge, dea          | th occurred at the ti   | ime, date and place                    | e, and due to the               | e cause(s) and   | manner as               | stated.   |
|                     | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical          | (Check only one)  2 Medical Examiner: On the and m   | basis of examina<br>anner stated.                                  | ation and/or i        | nvestigation, in my   | opinion, death occu                    | urred at the time               | e, date and plac | e, and due              | e to the cause(s)                               |
|                     | To th<br>withir<br>To th<br>comp   | Me               | 29b. Signature and title of certifier  | . 1  |                       | 29c. Licens   | se number                              |                                 | 29d. Date sig    | ned (Monti              | h, Day, Year)                                   |
| )                   | /  |                  | John W. Mrs  | dollet   | m ph                  | ウラ  | 2544                                   | / 3                             | 8/9              | 120                     | 07  |
|                     | 5  |                  | 30. Name and address of person who completed c | tuse of death (Iter  | n 23a) (Type          | Print)  | e we                                   | tomins                          | tor,             | mi                      | 12157   |
| ŀ                   | St   | ate              | 31. Date filed (Month, Day, Year) 37   | Registrar's Signa  | ature                 | aste 1  | 1                                      |                                 | ,                |                         |   |
|                     | Regist   | rar              | AUG 1 4 2007 2   | Device &   | 1 /5                  |   |  |                                 |                  |                         |   |

|            |  | -               | For<br>State<br>Registrar   | State of Mar  | -  | artment of H<br>rtificate of I           |  |                                      | ene<br>. No. 4 A A T                           | benot  |
|------------|--|-----------------|---|---|--|--|--|--------------------------------------|--|--|
|            |  |                 | 1. Decedent's Name (First, Middle, Last)  |   |  |  |  | Date of Death<br>Month               | Day Year                                       | 3. Time of Death                                   |
| <          | Physicia<br>/Medic   |                 | Melvin Duane Uhl  |   |  |  |  | August                               |  | 12:38PM  |
|            | Examin   | er              | 4a. Facility Name (If not institution, give s   | treet and number)   |  | 4b. City, Town, or                       | r Location of Death                      |                                      | 4c. County of Death                            |  |
|            |  |                 | 519 Maryland Ave. 5. Social Security Number 6. Sex  | 7 4 70  | (In yrs. last birthday)                      | Catonsv<br>If Under 1 Year               | ille<br>I if Under 24 Hrs.               | 8. Date of Birth                     | Baltimore                                      | place (State or Foreign                            |
|            | Funeral<br>Director  |                 | 511-50-6448   | M 2□F   | 58 Yrs.                                      | Months Days                              | Hours Min.                               | (Month, Day, Y                       | 948 Kan  | intry)   |
|            | and w  | -               | Usual Residence of Decedent  10a. State 10b. County   | 1   | 10c. City, Town or Lo                        | cation                                   | <u> </u>                                 |                                      |  | 10d. Inside City Limits                            |
|            | Maryli<br>f sho<br>led at  | 5               | MD Baltimor   |   | Catons                                       | ri 110                                   |  |                                      |  | 1 □Yes 2 No  |
|            | the 28a-<br>notif  | Director        | 10e. Street and Number  |   | Catonsy                                      | 10f. Zip Code                            |  | 100                                  | g. Citizen of What Cou                         | intry?   |
|            | 3a or  | O E             | 519 Maryland Ave  |   |  | 21                                       | 228                                      | Ι.                                   | nited Stat                                     | es.  |
|            | deatl  | Funeral         |   | 12. Was Decedent Ev   | ver in U.S. 13.1                             |  | lispanic Origin? (Spean, Mexican, Puerto |                                      | 14. Race - Ameri<br>Black, White               | ican Indian,                                       |
| 21215-0036 | be filed within 72 hours after death with the Maryland that Hyglene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at  | by              | 1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 Yes 2 No<br>If Yes, Give<br>Year or Dates:                              | 1967 <b>-</b><br>2002                        | 1 □ Yes 2 🔀 No                           | Specify:                                 | ,,                                   | Specify:                                       | White  |
| ŏ          | 2 hou  | ted             | 15. Decedent's Edu  |   | 16a. Dece                                    | dent's Usual Occup                       | ation<br>during most of worki            | 16                                   | 6b. Kind of Business/li                        | ndustry  |
| 215        | within 7<br>ene.<br>than "r<br>he Med  | Completed       | (Specify only highest grade<br>Elementary/Secondary (0-12)  | College (1-4or 5+)  | `life.                                       | DO NOT use retired                       | danny most or work.                      | , ig                                 | M  |  |
|            | e filed within<br>al Hygiene.<br>I other than '<br>vent, the Me  | S               | 12  |   | Sale   | 2s                                       | 40 Mathada Nasa                          | /Fires 84idale 84i                   | Manufact                                       | uring  |
| Maryland   | be fill<br>htal H<br>rd oth  | Be              | 17. Father's Name (First, Middle, Last)   |   |  |  | 18. Mother's Name                        | ·                                    |  |  |
| 7 18       | 2 should be<br>and Mental<br>is marked of<br>aumatic ev  | ဥ               | Gerald Duane Uhl  19a. Informant's Name/Relationship (Ty  | ne Print)   | 19h Mailir                                   | na Address (Street                       |  | Pearl Le                             | ΟΠΆΓΟ<br>City or Town, State, Z                | in Code)   |
| Ma         | d 2 sl<br>th an<br>7 is r<br>traur   |                 |   |   |  |  |  |                                      |  |  |
|            | 1 an<br>Heal<br>tem 2  |                 | Kratina M. MacKay  20a. Method of Disposition   | / daugnte   | 20b. Place of Dispo                          | Mary Land<br>sition (Name of             | Ave. Cat                                 | onsville<br>Pate 20                  | Maryland<br>Oc. Location - City or 1           | own, State   |
| lon<br>I   | ages<br>ent of<br>rt: If ii  |                 | 1 ☐ Burial 2 ☐ Cremation 3 ☐ F  | lemoval from State  | 1  | matory or other place                    |  | 4-2007                               | donton Mo                                      | w.lond   |
| Baltimore, | nit. Frantme   |                 | 21. Sign, thre of Furerai Service Licens  | 99.00   | West Alui                                    | 2. Name and Addre                        | ss of Facility Amb                       | rose Fun                             | denton, Ma<br>eral Home,                       | Inc.   |
| ñ          | permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic evonce.   |                 | JOAN DALL   | MILK  | 01   | 1328 Sulp                                | hur Sprin                                | g Rd Bal                             | timore, Má                                     | ryland 21227                                       |
| 68760, S   | Physician / Medical Examiner physician and physician and strength strength and physician situation of the physician strength and physicia | edical Examiner | 23a. Part1, Enter the disease or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a   | consequence of):  consequence of):           | otic ca                                  | Micoaso                                  | sular D                              | 150650   | Interval Between<br>Onset and Death                |
| .O. Box    | ath certif   | Physician/Med   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome p<br>1 Live birth 2<br>4 Pregnant at ti<br>9 Unknown | Fetal death 3                                | □Ectopic pregnanc<br>□ Other (specify) _ | у  |                                      | 23d. Date of deli<br>Month                     | very<br>Day Year                                   |
| Δ.         | juires that the de<br>n signed by the a<br>lid be detached I   | þ               | Part II. Other significant conditions co  | ntributing to death but   | not resulting in the u                       | inderlying cause giv                     | ven in Part I.                           | 23e. Did toba                        | acco use contribute to<br>3 2 □ No 3 □ Pro     |  |
| Records,   | The law requir<br>cate has been si<br>page 2 should l  | Completed       |   |   |  |  |  | 24a. Was an autopsy perform          | prior to c                                     | topsy findings available<br>completion of cause of |
| Vital      |  | Be C            | 25. Was care referred to medical examiner?  | -77/11 - 1 - 2 - 2 - 2  |  | 0.82                                     | 26. Place of Deat                        | h (Check only one                    | )  |  |
| or V       | <u>≥</u> . <u>≤</u>  | 2               | 1 Yes 2 No  | Hospital:<br>1 ☐ Inpatien   |  |  | 4 □ Nursing Ho                           |                                      | nce 6 Other (Spec                              | ify)   |
|            | fe<br>ne   |                 | 27. Mann of Death  1 Natural 5 Pending  | 28a. Date of Injury<br>(Month, Day  |  | Wo                                       |  | 28d. Describe how                    | v injury occurred                              |  |
| Division   | in at a  | Certification:  | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined   | 28e. Place of injur<br>building, etc.                                     | y - At home, farm, st<br>(Specify)           |  | Yes 2 □ No                               | 28f. Location (Stre<br>City or Town, | eet and Number or Ru<br>State)                 | ral Route Number,                                  |
|            | To the Hospital or Atte<br>within 24 hours after de<br>To the Funeral Directo<br>completely filled in by th  |                 | 29a. Certifier 1 Certifying Phy   | sician: To the best of  | f my knowledge, dea<br>examination and/or in | th occurred at the ti                    | ime, date and place,                     | and due to the ca                    | use(s) and manner as<br>ite and place, and due | stated. to the cause(s)                            |
|            | To the H<br>within 24<br>To the F<br>complete  | Medical         | one) 29b. Signature and title of certifler  | and manner stat   | ed.  | 29c. Licens                              |  |                                      | d. Date signed (Monti                          |  |
|            |  |                 | 1 halland 1   | ND Det  | istor  | DI                                       | 8667                                     | 1                                    | Lucus Tu.                                      | 2007   |
|            | 1041   | 9               | 90. Name and address of person who o  | ompleted cause of de  | ath (Item 23a) (Type,                        | 3 7                                      | II CT. L                                 | 4 there?                             | . , 0  | 21093  |
| 72         | Sta<br>Regist  |                 | 31. Date filed (Month, Day, Year)   | 32. Registra  |  | will .                                   |  |                                      | ı  |  |

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 10.15 AM Voll 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balkmore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Philadelphia, PA 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2 F Director Nov. Usual Residence of Decedent 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Heatth and Mental Hygiene. ant of Heatth and Mental Hygiene. ant; if item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number eamei. by Funeral Was Decedent Ever in U/S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Widowed 4 □ Divorced Whit Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DWN Kel Baltimore, Maryland 17. Father's Name (First, Middle, Lagt) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important; if item 27 is marked only injury or other traumatic ev ဂ္ Memia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) 19a Harford Creamery Uhite Hall MD 21161 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State thwood Cemetery 8/15/07 Philadelphia PH

22. Name and Address of Facility New port D. Forest H. 11, MD 21050 1 ABurial 2 ☐ Cremation 4 Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Dicense Evens Funeral Chasel + Cremation 23a. Part1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ung cancer years /Medical Due to (or as consequence of) ef si Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of) or Vital Records, P.O. Box 68760 or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an has autopsy performe 1□ Yes 2 certificate 2 X No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, 2401 W. Belveder, Ave Agarna Gadekar, That Hospital Hospital Signature 31. Date filed (Month, Day, Year) State AUG 1 4 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician**  ${\mathbb A}^{\mathsf M}$ 2007 Lalah C. Welch August 12 7:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Morningside House of Laurel Laurel Prince George's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months 1 ☐ M 2X F Director 578-07-0557 95 May 19, 1912 Virginia Usual Besidence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f shov notified at 1 ☐ Yes XXNo Director MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be re 236 Spring Gap S. 20724 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ Specify Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) National Association Elementary/Secondary (0-12) College (1-4or 5+) of Home Builders Advertising Manager 12th Ø 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Thomas J. Carr Lilly Gardner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William G. Many, Sr. /Nephew Spring Gap S. , Laurel, MD 20724 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 8/16/2007 Suitland, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses anen ody M01103 313 Talbott Avenue, Laurel, 23a. Part1. Into the disease, or complications had caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or mart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C - e (Final disease or condition resulting in death) **Physician** Congestive Heart Failure 3 months /Medical Due to (or as a consequence of) **Examiner** Hypertensive Heart Disease 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami Chronic Recurrent Pulmonary Embolism 5+ years Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Advanced Age Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2X No 24a. Was an page 2 autopsy perform 1□ Yes 2**/**2XNo To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 Nursing Home 5 Residence 6 AOther (Specify) Living 1 ☐ Yes 2X No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: s after decrain Atternation 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide \*\*\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760,

10

Baltimore, Maryland 21215-0036

State Registrar

Medical

(Check only one)

29b. Signature and title\_of certifier

14201 Laurel Park Drive,

32. egistrar's Signature 31. Date filed (Month,-Day, Year)

30. Name and address of person who compete cause of death (Item 23a) (Type, Print)

Laurel, MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

20707

29c. License number

D13671

29d. Date signed (Month, Day, Year)

Dr. B.G. Manejwala

August 13, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** David Henry Walton 10, 2007 12:45  $A^{M}$ August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Center Lutherville Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/17/1933 Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 216-32-5141 73 Director Virginia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Maryland Baltimore White Marsh r 28a-f sh notified 1 Yes 2XXIO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o e 10501 Vincent Road "natural", or items 23a dical Examiner must b 21162 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ÎÑ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2√No Korea Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ed other than 'event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Box Manufacturer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilson Walton Marion Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trau once. Carolyn Walton (Wife) 10501 Vincent Road, White Marsh, Maryland 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Belair Mem. Gardens | 08/14/2007 | Bel Air, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Bruzdzinski Funeral Home , P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. For the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia: Cause (Final disease r condition resulting in death) Physician PROSTATE CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1∐ Yes 2**X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 No 2 ER/Outpatient 3□ DOA 2 HOSPICE 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification:

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician:

AUGUST

the Funeral Director: npletely filled in by the

 Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certif 29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

Injury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State Registrar

1 X Natural 2 ☐ Accident

3 Suicide

5 Pending investigation

6 Could not be determined



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner RITCHIE NIA MORE HOSPICE If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)

ARYLAND 5. Social Security Number 7. Age (In yrs, last birthday) 6. Sex **Funeral** Months Davs 1 ☐ M 2 💢 F -68-487 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Yes 2 No Completed by Funeral Director NIA MARYIAND 10e. Street and Number 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ST. SALTO, HO 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10N 22. Name and Address of 21. Signature of Funeral Service Licensee lans TON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastati unknown /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed and physician and use as the burial-tran Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Day Year 5 Other (specify) 1 Yes 2 No been signed by the a should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 3 Probably 4 □Unknown 2 No 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 this certificate has autopsy performed? res 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sether (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No in by the within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richey Hospice 538 / S2. Registrar's Signature 150 MD

State Registrar

31. Date filed (Month, Day, Year)

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 8, Day 2007 Year **Physician** Leroy D. Williams 11:25 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Avenue Parkville Baltimore 9430 Ridgely Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) May 7, 1920 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex **Funeral** Days 1 XM 2 ☐ F 215-12-2889 May Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Maryland Baltimore Parkville 1 ☐ Yes XXNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 9430 Ridgely Avenue USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify: Specify: White 3 Widowed 4 Divorced Completed injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grummans Aircraft Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Williams Minnie Gertrude May 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Pearce Daughter 9430 Ridgely Avenue, Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of h Important: If ite 1 Burial 2 □ Cremation 3 □ Removal from State 8/11/2007 Woodlawn Cemetery Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc.
3631 Falls Road, Baltimore, Maryland 21. Signature of Funeral Service License 23a. Path. Ent., the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or its art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a con equence of): Failore 24 hours /Medical Examiner Intumamia Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death ed by the a detached 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2☐No 3☐ Probably 4☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 125HO page 2 autopsy performed or Attending Physiclan: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred : After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

LXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 31295

Suite 4202

29d. Date signed (Month, Day, Year) 8/13/57

mil

710000

Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: To the Hospital

> State Registrar

DHMH 17 Rev 1/2001

Medical

(Check only

Wend

29b. Signature and title of certifier

31. Date filed (Month, Day,

Klopsz

Year)

**ORIGINAL** 

32. Registrar's Signature

6701 N Chinus

30. Name and address operson who completed cause of death (Item 23a) (Type, Print)

2007

07-06045 Stephen Wolk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| December 1 Service   Proposed of the propose   | ohen Wolk                          |            |                                      | e of Marylar          | nd / Depar          | tment of         | Health and            | d Mental                         | Hygiene                      | 5 N           | 0                | 11              | 2609               |
|--|------------------------------------|------------|--------------------------------------|-----------------------|---------------------|------------------|-----------------------|----------------------------------|------------------------------|---------------|------------------|-----------------|--------------------|
| Sephen Wolk  Filtred  |                                    | F          | Panistrar                            | net)                  | Certi               | ilicate of       | Death                 |                                  |                              | Death         |                  | 3. Time of D    | eath               |
| The Facility Numer of Test institution, gover serves and number)  Sport Department of Test institution of Department of Sport Number of Test institution of Department of Sport Number of Test institution of Department of Depart |                                    |            |                                      | 15()                  |                     |                  |                       |                                  | Month<br>August              | 6, 2007       | Year             | 2204 h          | rs                 |
| SOUTH Comparison of Decident State   1.79 - 34 - 4.685   1.7 × 2   |                                    |            |                                      | jive street and num   | nber)               | 4                |                       | Location of De                   | eath                         |               |                  |                 |                    |
| Type-34-4-685 X M 2 F 64 Yrs, football loss, footba |                                    |            |                                      |                       |                     |                  |                       |                                  |                              |               |                  |                 | 05                 |
| Type-34-4-655   X b z   564   Ye   April 10,1943   Oblinity    Type-34-655   X b z   564   Ye  | Funeral                            |            | Social Security Number     6.        | Sex 7                 | 7. Age (In yrs. las | st birthday)     |                       |                                  |                              |               |                  | ign Penns       | ylvania            |
| No. State   Table   Country   Table    | Director                           |            | 179-34-4685                          | X M 2 F               | 64                  | Yrs.             |                       |                                  | Apri                         | il 10,        | 1943             | ountry)         |                    |
| No.   Section    |                                    | ļ          |                                      |                       | 140a City T         | Fown or Locati   | 00                    |                                  |                              |               |                  | 10d. Inside     | City Limits        |
| Never Married 2 X Married 3 X Married 3 X Married 4 Developed Process of the Company of the Comp | w any                              |            | 10a. State 10b. County               |                       |                     |                  | 511                   |                                  |                              |               |                  | 1 X Yes         | 2 No               |
| Never Married 2 X Married 3 X Married 3 X Married 4 Developed Process of the Company of the Comp | land<br>-f sho                     | ġ          | Maryland Montgom                     | ery                   | KOCK                | viiie            | 10f. Zip Code         |                                  |                              | 10g. Citi:    | zen of What Co   | ountry?         |                    |
| Never Married 2 X Married 3 X Married 3 X Married 4 Developed Process of the Company of the Comp | Mary<br>r 28a                      | ie         |                                      |                       |                     |                  | 20852                 |                                  |                              | Unit          | ed Stat          | tes             | 1                  |
| New Manifed 2 X Memory 19 1 Note of the Control of Specific Vision (Specify of Control of Specify Of Control of Specify Vision (Specify Of Control of Specify Of Control of Specify Of Control of Specify Of Control of Specify Vision (Specify Of Control of Specify Of Contr | ith the                            | 믵          |                                      | Drive<br>12. Was Dece | edent Ever in U.S   | 6. 13. Wa        | s Decedent of His     | spanic Origin?                   | ( Specify Yes o              | r No-         |                  |                 | Black,             |
| Burlal 2 X Cremation 3   Removal from State   Port Lincoln Crematory   State   Port Lincoln Crema   | ath w                              | ner        |                                      | ied Armed Fo          | rces?               | If Y             | es, specify Cubar     | n, Mexican, Pu                   | ierto Rican, etc.            | )             |                  |                 |                    |
| Burial 2 X Cremation 3   Removal from State   Contributing to ceath but not resulting in the underlying cause given in Part I.   Type 2   No 9   Unknown   Part II. Other significant conditions   Contributing to ceath but not resulting in the underlying cause given in Part I.   Type 2   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.    | ter de                             |            | 3 Widowed 4 Divord                   |                       |                     |                  | ^                     |                                  |                              |               |                  |                 |                    |
| Burlal 2 X Cremation 3   Removal from State   Port Lincoln Crematory   State   Port Lincoln Crema   | ours af<br>itural                  | d b        | 15. Decedent's Education (Specif     |                       |                     | 16a. Deceder     | nt's Usual Occupa     | tion (Give kind<br>b. DO NOT use | d of work done<br>e retired) | 16b. I        | Kind of Busines  | ss/industry     |                    |
| Burlal 2 X Cremation 3   Removal from State   Port Lincoln Crematory   State   Port Lincoln Crema   | 72 ho                              | lete       | Elementary/Secondary (0-12)          |                       |                     |                  |                       |                                  |                              |               | Psycho           | logy            |                    |
| Burlar   2 Xeremation   3 Removal from State   Fort Lincoln Crematory   1   Burlar   2 Xeremation   3   Removal from State   Fort Lincoln Crematory   22. Name and Address of Facility   1   Fort Lincoln Crematory   22. Name and Address of Facility   1   Fort Lincoln Crematory   22. Name and Address of Facility   1   Fort Lincoln Crematory   22. Name and Address of Facility   1   Fort Lincoln Crematory   22. Name and Address of Facility   1   Fort Lincoln Crematory   22. Name and Address of Facility   1   Fort Lincoln Crematory   22. Name and Address of Facility   1   Fort Lincoln Crematory   22. Name and Address of Facility   1   Fort Lincoln Crematory   22. Name and Address of Facility   1   Fort Lincoln Crematory   22. Name and Address of Facility   22. Name and Address of   | vithin ene.                        | m<br>du    |                                      |                       |                     |                  | Rescar                |                                  | Name (First, Mid             | 1             |                  | 1087            |                    |
| Burial 2 X Cremation 3   Removal from State   Contributing to ceath but not resulting in the underlying cause given in Part I.   Type 2   No 9   Unknown   Part II. Other significant conditions   Contributing to ceath but not resulting in the underlying cause given in Part I.   Type 2   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.    | Filed v<br>Filed v<br>Hygi         |            |                                      | ast)                  |                     |                  |                       |                                  |                              |               |                  |                 |                    |
| Burial 2 X Cremation 3   Removal from State   Contributing to ceath but not resulting in the underlying cause given in Part I.   Type 2   No 9   Unknown   Part II. Other significant conditions   Contributing to ceath but not resulting in the underlying cause given in Part I.   Type 2   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.   Type 3   No 9   Unknown   Type 3   North Part II.    | 112<br>Id be<br>Menta<br>marke     |            | 19a. Informant's Name/Relationshi    | p (Type, Print )      |                     | 19b. Mailin      | g Address (Stre       | et and Numbe                     | er or Rural Route            | Number, C     | City or Town, St | ate, Zip Code)  |                    |
| Burlal 2 X Cremation 3   Removal from State   Port Lincoln Crematory   State   Port Lincoln Crema   | ID Stoom                           | -          |                                      |                       |                     | 6037             | Loganwo               | od Driv                          | ve. Rocl                     | cville        | MD 20            | 0852            |                    |
| Tysician in dical saminer  28. Part II. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory enters. Shock, or least a failure. List only one cause or each line. Immediate Cause (Firal disease or condition resulting in death)  29. Sequentially list conditions, any least study and the cause or each line. Immediate Cause (Firal disease or complications that cause or each line. Immediate Cause (Firal disease or condition resulting in death)  29. Sequentially list conditions, any least study and the cause or each line. Immediate Cause (Firal disease or condition resulting in death)  29. Sequentially list conditions, any least resulting in death)  29. Worder and the cause of the cause or each line. Immediate Cause (Firal disease or conditions)  20. In the cause of the cause o | e, N<br>and 2<br>Health<br>item 3  |            | 20a, Method of Disposition           |                       |                     | lace of Diopo    | Oldieri ( . ianii e e |                                  |                              | 77            |                  |                 |                    |
| Tysician in dical saminer  28. Part II. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory enters. Shock, or least a failure. List only one cause or each line. Immediate Cause (Firal disease or condition resulting in death)  29. Sequentially list conditions, any least study and the cause or each line. Immediate Cause (Firal disease or complications that cause or each line. Immediate Cause (Firal disease or condition resulting in death)  29. Sequentially list conditions, any least study and the cause or each line. Immediate Cause (Firal disease or condition resulting in death)  29. Sequentially list conditions, any least resulting in death)  29. Worder and the cause of the cause or each line. Immediate Cause (Firal disease or conditions)  20. In the cause of the cause o | ages 1<br>nt of 1                  |            |                                      |                       | om State            |                  |                       |                                  |                              | l Ri          |                  |                 |                    |
| Again of the condition resulting in death to the cause on each line.  23. Part II. Enfer the disease, or completations that cause on each line.  24. Probable Cardiac arrhythmia  25. Equation in mediate Cause (Final disease or condition resulting in death)  25. Equation in mediate Cause (Final disease or condition resulting in death)  25. Equation in mediate Cause (Final disease or condition resulting in death)  25. Equation in mediate cause. Enter Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that initiated eave better Underlying Cause (Disease or injury that Initiated eave better Underlying Cause (Disease or injury Underly Underl  | Atin<br>nit P<br>artme             |            | 21 Signature of Funeral Service      | icensee               | 101                 | 22.              | Name and Addres       | s of Facility                    | Simple<br>1040 Ro            | Tribu         | ite<br>Lle Pik   | e               |                    |
| As Procession and the disease of complications that caused the death. Do not disease or conditions failure List only one cause of each mine list of long cause of each mine failure. List only one cause of each mine failure. List on the failure accurate and mine failure. List on the failure accurate and mine failure. List on the failure accurate and mine failure. List one cause of each mine failure. List of each mine failure. List of each mine failure. List on the failure accurate and mine failure. List o  | Dep<br>Imp                         |            | Centum Basch                         | / Woody               |                     |                  |                       |                                  | Rockvi.                      | lle, N        | ① 2085           | 2<br>Approxim   | nate Interval      |
| Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition is death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that littled events resulting in death) Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in death). Last (Disease or injury that littled events resulting in the underlying cause given in Part I.  You would be a proving that the past 12 months?  Part II. Other significant conditions of contributing to death but not resulting in the underlying cause given in Part I.  Yes 2 No 3 Probably 4  24a. Was an and part or completic death). It was a proper performed?  Yes 2 No 3 Probably 4  25b. Was case referred to medical examiner or Death (Disease or injury). Yes 2 No 2 N  |                                    |            | 23a. Part I. Enter the disease, or c | n each line.          |                     |                  |                       | g, such as car                   | diac or respirate            | ry arrest, si | lock, of flear   | Between         | Onset and<br>Death |
| The Continuity of the second of the cause of |                                    |            | Immediate Cause (Final disease       | a. Probable           | e cardiac           | arrhyth          | nia                   | •                                |                              | _             |                  | _               |                    |
| Sequencially its controlling in death of the cause of the cause. Either Underlying Cause (Disease or Injury that Inflated events resulting in death) Last devents resulting in death but not resulting in the underlying cause given in Part I.    FEMALE: 28. Was doosdent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   1 Live birth   23c. May doosded the regnant at time of death   23c. May doosded the regnant at | .Adminici                          |            | or condition resulting in death)     |                       |                     |                  |                       |                                  | 4                            |               |                  |                 |                    |
| No.   Composition   Complete   Composition   Complete   |                                    | <u>_</u>   | Sequentially list conditions,        |                       |                     |                  |                       |                                  |                              |               |                  |                 |                    |
| No.   Composition   Complete   Composition   Complete   |                                    | i i        | cause. Enter Underlying Cause        | c                     |                     | . 6:             |                       |                                  |                              | _             |                  |                 |                    |
| The light of the latter of t   | d<br>sit                           | xar        | events resulting in death) Last      | Due to (or as a       | a consequence o     | of):             |                       |                                  |                              |               |                  |                 |                    |
| FEMALE:   23c. If yes, outcome of pregnancy   2   Fetal death   3   Ectopic pregnancy   Month   Day  | xecute<br>n and<br>- tran          | 1 =        | VUNDENDED                            | d.                    |                     | 070 0            | /0.1./07 FFF          |                                  |                              |               |                  |                 |                    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.    23e. Did tobacco use contribute to the cause of the property of the  | 0,<br>e be e<br>ysicial<br>burial  | ig         | A ONFENDED                           |                       |                     |                  | /24/07_11_            |                                  |                              | 2             | 3d. Date of del  | ivery           |                    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.    23e. Did tobacco use contribute to the cause of the property of the  | 876<br>tificat<br>ng phy<br>as the | N N        | 23b. Was decedent pregnant in the    | e 1 Live              | birth               | 2 F              | etal death            | B Ectopic                        | pregnancy                    |               | Month            | Day             | Year               |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.    23e. Did tobacco use contribute to the cause of the underlying cause given in Part i.  | x 6<br>th cer<br>ttendi            | 1 :5       | past 12 months:                      |                       |                     | eath 5           | Other (Specify)       |                                  |                              | -             |                  |                 |                    |
| 29b. Signature and title of Certifier  O.C.M.E.  August 7, 2007  | Bo<br>ne dea<br>r the a<br>hed fo  | 1 5        | Dat II Other significant conditi     |                       |                     | resulting in the | e underlying caus     | e given in Par                   | t i. 23e                     | . Did tobaco  | co use contribu  | te to the cause | of death?          |
| 29b. Signature and title of Certifier  O.C.M.E.  August 7, 2007  | that the ned by detacl             | 1 2        |                                      | ona contributing      | (0 000              |                  | , ,                   |                                  | 1 [                          | Yes 2         | <b>✓</b> No 3    | Probably 4      | Unknown            |
| 29b. Signature and title of Certifier  O.C.M.E.  August 7, 2007  | S, F<br>quires<br>an sign          | 1 5        |                                      |                       |                     |                  |                       |                                  | 248                          |               | 24b. We          | re autopsy find | ings available     |
| 29b. Signature and title of Certifier  O.C.M.E.  August 7, 2007  | ord<br>aw rec<br>as be             | 2          | <u> </u>                             |                       |                     |                  |                       |                                  | _                            | performed     | ? dea            | th?             | 2 No               |
| 29b. Signature and title of Certifier  O.C.M.E.  August 7, 2007  | Rec<br>The Licate Page             | ځ ا        | <u> </u>                             |                       |                     |                  | ne Die                | aco of Death (                   |                              |               | NO I             | 103             | 2 110              |
| 29b. Signature and title of Certifier  O.C.M.E.  August 7, 2007  | tal  <br>cian:<br>certif<br>ector, | 1 0        | 25. Was case referred to medical     |                       | Innationt 2         | ER/Outpatie      |                       |                                  |                              |               | idence 6         | Other: Scene    |                    |
| 29b. Signature and title of Certifier  O.C.M.E.  August 7, 2007  | F Vid<br>Physic<br>rr this         | F          | 1 ✓ Yes 2 No                         |                       |                     |                  |                       | njury at Work                    |                              | -             |                  |                 |                    |
| 29b. Signature and title of Certifier  O.C.M.E.  August 7, 2007  | n Of<br>ding                       | ;          | 1 X Natural 5 Penc                   | (Mon                  | nth, Day, Year)     |                  | 1                     | Yes 2                            | No                           |               |                  |                 |                    |
| 29b. Signature and title of Certifier  O.C.M.E.  August 7, 2007  | SiO                                | 5          | 2 Accident Inves                     | stigation 28e. Pla    | ace of Injury - At  | home, farm, st   | treet, factory, offic | ce building, etc                 | c. 28f. Loc                  | cation (Stree | et and Number    | or Rural Route  | Number, City       |
| 29b. Signature and title of Certifier  O.C.M.E.  August 7, 2007  | Divi                               | 3 3        | 3 Suicide 6 Coul                     | d not be              |                     |                  |                       |                                  | or                           | Town, State   | ·)               |                 |                    |
| 29b. Signature and title of Certifier  O.C.M.E.  August 7, 2007  | lospit<br>4 hour<br>uners          | ~ I        |                                      | hysician: To the b    | est of my knowle    | edge, death oc   | curred at the time    | e, date and pla                  | ice, and due to t            | he cause(s)   | and manner a     | s stated.       | . \                |
| 29b. Signature and title of Certifier  O.C.M.E.  August 7, 2007  | the I<br>thin 24<br>the F          | in provide | one) 2 Medical Exa                   | miner: On the basis   | is of examination   | and/or investi   | igation, in my opir   | nion, death oc                   | curred at the tim            | ie, date and  | place, and date  |                 | )                  |
|  | S in it is                         | 3          | 29b. Signature and title of certific |                       | 11                  | ,                |                       |                                  |                              |               | -                |                 | rear)              |
| 77 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4   |                                    |            |                                      | M/h 1                 | 1                   |                  | 0.                    | C.M.E.                           |                              |               | rogust /, 20     |                 |                    |
| 30. Name and address of person who completed cause of death (Item 23a)   |                                    |            | 30. Name and address of persor       | who completed ca      | ause of death (Ite  | em 23a)          |                       | 2014:                            | MD 04004                     |               |                  |                 |                    |
| Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  |                                    |            | Jack Titus MD. V De                  |                       | 7                   |                  |                       | saitirnore,                      | IVID 2 IZU I                 |               |                  |                 |                    |
| State Registrar  31. Date filed (Aprilis Clay, Year) Registrar  Registrar  |                                    |            | te 31. Date filed (Month Day, Year)  | 2007                  | Registrar's Sign    | S A              | and I                 |                                  |                              |               |                  |                 |                    |

|                   |  |                  | 1 - For Amen  | d 20a-c,22,                             | State of<br>perFH, G87   |  |                                  |                                   |                           |                                       |                            | ental Hyg                                  |                       | 2007  | 26                         | 094         |
|-------------------|--|------------------|---|---|--|--|----------------------------------|-----------------------------------|---------------------------|---------------------------------------|----------------------------|--|-----------------------|---|----------------------------|-------------|
|                   | Ti, Aji  |                  |   | ne (First, Middle, La                   | st)  |  |                                  |                                   |                           |                                       |                            | 2. Date of Deat                            | h                     |   | 3. Time                    | of Death    |
|                   | Physic<br>/Medi  |                  |   | YNTH                                    | 14   | WAK  | KE                               |                                   |                           |                                       |                            | Month<br>4UGUS                             | TO                    | 6 2007  | 09:0                       | 00 AM       |
|                   | Exami  |                  |   | (If not institution, giv                | e street and numb  | er)  |                                  | 4b. City,                         | Town, or                  | Location o                            | of Death                   |  |                       | County of Death                                   |                            |             |
|                   |  | 4 1 4            |   | KECAR                                   |  |  |                                  |                                   |                           | rstu                                  |                            |  | 1                     | 3FLT11  | noke                       | <u></u>     |
| ×.                | Funeral<br>Director  |                  | 5. Social Security I  | 4242 1                                  | ex   | Age (In yrs.   | Yrs.                             | Months Months                     |                           | If Under<br>Hours                     | Min.                       | B. Date of Birth<br>(Month, Day,<br>ctuber | Year)                 | 9. Birthp<br>Cour<br>1956 U                       | lace (State<br>try)<br>NKU | or Foreign  |
|                   | /land  |                  | 10a. State  | 10b. County                             |  | 10c. Cit   | y, Town or L                     | ocation                           |                           |                                       |                            |  |                       | 1   | Od. Inside (               | City Limits |
|                   | Man  | ţċ               | MD  | Baltimo                                 | re   | R  | eiste:                           | stown                             | n.                        |                                       |                            |  |                       |   | 1 TYe                      | s 2X No     |
|                   | th with the<br>23a or 28<br>and be not   | Funeral Director | 10e. Street and Nu<br>12020 R   | eistersto                               | wn Road  |  |                                  | 10f. Zip                          | o Code                    | 21136                                 | ó                          | 1  | 0g. Citiz             | ten of What Cour                                  | ntry?                      |             |
| 36                | be filed within 72 hours after death with the Maryland hal Hygiene. Id other then "natural", or iteme 23a or 28e-f show event, the Mcdical Exerdice roust by notified at   | by Funer         | 11. Marital Status 1 □ Never Mari   | ried 2∏ Married                         | 12. Was Decede<br>Armed Force<br>1 Yes 2<br>If Yes, Give<br>Year or Date | es?<br>M⊠No  |                                  | Was Dece<br>If Yes, spe<br>1  Yes |                           | ispanic Ori<br>n, Mexican<br>Specify: | gin? (Spec<br>i, Puerto Ri | fy Yes or No-<br>ican, etc.)               |                       | 4. Race - Americ<br>Black, White,<br>Specify: bla | etc.                       |             |
| 21215-0036        | 2 hou<br>atura   | ted              |   | 15. Decedent's Ed                       | ducation   |  | 16a. Dece                        | dent's Usu                        | al Occupa                 | ation                                 |                            |  | 16b. Kir              | d of Business/In                                  | dustry                     |             |
| 215               | hin 7  | pie              | (Spe<br>Elementary/Sec  | cify only highest gra                   | de completed) College (1-4   | or 5+)   | (Give                            | kind of wo<br>DO NOT u            | ork doné a<br>se retired, | du <i>ring</i> mosi<br>')             | t of working               | 7  |                       |   | •                          |             |
| 21                | filed with<br>Hygiene<br>sther the   | Completed        | 12  |   | 0  |  | (                                | cook                              |                           |                                       |                            |  | car                   | ry out s  | hops                       |             |
| nd                | be file<br>tal Hy<br>d oth   | Be               |   | (First, Middle, Last)                   |  |  |                                  |                                   |                           |                                       |                            | First, Middle, I                           | Aaiden :              | Sumame)   |                            |             |
| yla               | should be filed within nd Mental Hygiene. I marked other then umatic event, the Mental control of the Mental c | ို               | Jack Car  |   |  |  |                                  |                                   |                           |                                       |                            | Belon                                      |                       |   |                            |             |
| Maryland          | d 2 strau  |                  |   | lame/Relationship (<br>ennedy/son       |  |  |                                  |                                   |                           |                                       |                            |  |                       | Town, State, Zip                                  | Code)                      |             |
|                   | s 1 and if Heall item 2 other  |                  | 20a. Method of Dis  | sposition                               |  | 20b. P   | tace of Dispo                    | osition (Nai                      | me of                     |                                       | Da                         | -  |                       | eation - City or To                               | wn, State                  |             |
| m<br>0            | 00   |                  |   | Cremation 3 5                           |  | ate Gre  | emetery, cre.                    | •                                 | other place               |                                       | 8/17/2                     |  |                       | imore, MD   |                            |             |
| Baltimore,        | permit. Page<br>Department of<br>Important: if<br>any injury or<br>once.   |                  | 21. Signature of Fi   | uneral ervice Licer                     |  | 277  | ਤੰ                               | 2. N me a                         | unar.                     | s of Facility                         | March                      | F-H- Fos<br>21202                          | 110                   | ILE Nort  | <del>L Avet</del>          |             |
| 68760,            | Physician and // Medical Examiner and publication and publicat | cai Examiner     | Immediate Cause disease or condition resulting in death)  Sequentially list or flany, leading to incause. Enter Unde Cause (Disease or that initiated event resulting in death) | onditions. nmediate erlying injury s    | a. Me Due to (or b. Due to (o. c.  | as a consequal as a consequence as a consequal as a consequence as a consequen | ATIC<br>uence of):<br>uence of): |                                   |                           |                                       |                            |  |                       |   | Interval Be<br>Onset and   |             |
| P.O. Box 687      | death certific<br>e attending p<br>id for use as l   | Physician/Medic  | IF FEMALE: 23b. Was deceder in the past 12 1  Yes 2 9  Unknown  | months?                                 |  | n 2 ☐ Fetal<br>t at time of de   | death 3                          | □Ectopic pr<br>□ Other (sp        |                           |                                       |                            |  | 2                     | 3d. Date of delive<br>Month                       |                            | Year        |
|                   | The law requires that the site has been signed by the bage 2 should be detache   | by Pt            |   | ficant conditions o                     |  |  |                                  |                                   |                           |                                       |                            | 23e. Did tob                               | acco us               | e contribute to the                               | e cause of                 | death?      |
| ğ                 | w require<br>been sig<br>should b  |                  | BRA   | IN ME                                   | TASTA.   | SES  | WITH                             | HE                                | MOA                       | er H                                  | 46E                        | 1 □ Ye                                     | s 2 🗆                 | No 3□Prob   | ably 4 🗓                   | bnknown     |
| Records,          | e law requ<br>has been<br>je 2 should  | Completed        | HUMI  | AN IM                                   | MUNOU  | EFI  | CIEN                             | cy i                              | VIR.                      | us                                    |                            | 24a. Was ar                                |                       | 24b. Were auto                                    | osy findings               | available   |
| <u> </u>          |  | mo.              |   | -USE 1                                  |  |  |                                  |                                   |                           |                                       |                            | autops<br>perform                          | ned?                  | death?  |                            | cause or    |
| /ita              | i <b>cian</b> ; Th<br>certificate<br>rector, pag   | Be (             | 25. Was case reference examiner?  |   | 777-0-   |  |                                  |                                   |                           |                                       | of Death (                 | Check only on                              |                       |   |                            |             |
| <u>&gt;</u>       | y S  | ဥ                | 1 ☐ Yes 2 ☑   | NO                                      | Hospital: 1 ☐ Inp  | atient 2 🗆 I   | ER/Outpatier                     | nt 3 🗆 DC                         | Othe                      | 1. 4 Nui                              | rsing Home                 | 5 ☐ Reside                                 | nce 6                 | Other (Specify                                    | ')                         |             |
| Ë                 | ing P  | 0                | 27. Manner of Deat<br>1 Natural   | th<br>5 ☐ Pending                       | 28a. Date of I<br>(Month,  | njury<br>Day Year)   | 28b. Time o<br>Injury            |                                   | 8c. Injury<br>Work        | at<br>?                               | 28                         | d. Describe ho                             | w injury              | occurred  |                            |             |
| Division of Vital | of or Attending<br>after death.<br>I Director: After<br>d in by the fune   | Certification:   | 2 Accident 3 Suicide 4 Homicide   | investigation 6 Could not be determined | 28e. Place of  | Injury - At ho<br>etc. (Specify  | me, farm, str                    | M<br>reet, factory                |                           | /es 2□1                               |                            | f. Location (Sti<br>City or Town           |                       | Number or Rura                                    | l Route Nur                | nber,       |
|                   | To the Hospitel or Attending Ph<br>within 24 hours atter death.<br>To the Funeral Director: Atter thi<br>completely filled in by the funeral   | edical           | 29a. Certifier<br>(Check only<br>one)   | 1 ☐ Certifying Ph<br>2 ☐ Medical Exam   | ysician: To the be<br>liner: On the basis<br>and manner                  | s or examinar  | wledge, deat<br>ion and/or in    | h occurred<br>vestigation         | at the tim                | e, date and<br>inion, deat            | d place, and               | d due to the ca<br>at the time, da         | use(s) a<br>ite and i | and manner as st<br>place, and due to             | ated.<br>the cause(        | s)          |
|                   | To the<br>within<br>To the<br>comple   | Σ                | 29b. Signature and  | title of certifier                      |  |  |                                  | 290                               | . License                 | number                                |                            | 25   | d. Date               | signed (Month,                                    | Day, Year)                 |             |
| 1                 | 2  |                  | 10  | alth                                    | 3  |  |                                  |                                   | DOO                       | 5333                                  | 57                         |  | 8                     | -7-07   |                            |             |
| 1                 |  |                  | 30. Name and addr   | ress of person who                      | 2  | death (Item<br>35 Sv   |                                  |                                   | Q                         | - ما                                  | 7.15                       | Rult                                       |                       | e, Mdz  |                            |             |
|                   | Sta  | te               | 31. Date filed (Mon   |   |  | strar's Signat   |                                  | verue                             | - 0                       | JULITE !                              | 3                          | الكلالا                                    | Will                  | el mas  | 1209                       |             |
|                   | Registi  |                  |   |   | 007  |  |                                  | 100                               |                           |                                       |                            |  |                       |   |                            |             |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** WEINER JUDITH yust 2007 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltinune 04 Baltimare Sinai Hospital N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number 6. Sex **Funeral** Months 11/10/1932 1 ☐ M 2 💢 F 74 MD 217-30-2893 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No BALTIMORE BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21208 U.S.A. 45 FARMHOUSE COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TROTZKY SELETSKY BESS SAMUEL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45 FARMHOUSE COURT - BALTIMORE, MD 21208 KENNETH WEINER / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW 08/12/2007 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Sign ture of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Ana plastic **Physician** celllymakon years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any limit and immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2☐No 3☐ Probably 4☐Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ie Hospital or Attend 24 hours after death. ie Funeral Director: / 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 West Belveles Avere Baltonar Mayland 21215 32 Aegistrar's Signature 31. Date filed (Month, Day, Year) AUG 1 4 State

DHMH 17 Rev 1/2001

Registrar

| 07-06235<br>Sharon Melissa  | Allei          | Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene   | 6        |
|---|----------------|--|----------|
|   |                | 1- For State Certificate of Death Reg. No.   | 0        |
| Physicia<br>Medical Examii  |                | 1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year 0852 hrs  3. Time of Death 0852 hrs  |          |
|   |                | 4a. Facility Name (if not institution, give street and number)  Johns Hopkins Hospital  4b. City, Town, or Location of Death  Baltimore  4c. County of Death  N/A  |          |
| Funeral<br>Director   |                | 5. Social Security Number 6. Sex $39$ Yrs. $39$ If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Mary Ian   | ıd       |
| daryland<br>28a-f show any<br>1 at once.  | 'n             | Usual Residence of Decedent  10a. State  10b. County  Maryland  NA  Baltimore  10d. Inside City Limit  1 XYes 2 N  |          |
| ith the Maryland<br>23a or 28a-f she<br>notified at once  | Director       | 10e. Street and Number  18/10 N. Regester St.  10f. Zip Code  2/2/3  10g. Citizen of What Country?  USA  | Ti       |
| r death w<br>or items   | Funeral        | 11. Marital Status 1 Never Married 2 Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 No specify: Speci |          |
| 2 hours aft<br>"natural"  | ed by          | 15. Decedent's Education (Specify only highest grade completed)  16. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)  16. Kind of Business/Industry   |          |
| Bran 17   | Completed      | Elementary/Secondary (0-12)  12 th Grade  College (1-4 or 5+)  Licensed Cosmetulogist Self-Employed  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  |          |
| 21215<br>D 21215<br>houldrbe filee<br>nd Mental Hy<br>is marked of<br>utic event, th  | Be             | Willie H. Parker Edmonia P. Vaughn   |          |
| MD 2<br>d 2 shoul<br>lith and M<br>n 27 is m  | 2              | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town; State, Zip Code)  Edmonia P. Kolson (mother 1810 N. Regester St. Baltimore, Mis 2121)   | 3        |
| Baltimore, MD 21215-00.<br>sermit Pages I and 2 shouldbe filed with<br>Department of Health and Mental Hygiene<br>important: If item 27 is marked other th  |                | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, part of the place)  20c. Location - Cfty or Town, State (Suppose of Disposition)  20c. Location - Cfty or Town, State (Suppose of Disposition)  |          |
| Baltimore,<br>permit. Pages 1 an<br>Department of Hee<br>Important: If ite  |                | 1 Burial 2 Cremation 3 Removal from State Mayland Not11. Min. PK. Laurel MD  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Chotman—Harris Funeral Harris   | ソピ       |
| m உத்தத்<br>Physician   |                | Loroy Hours 5940 Ruster stown Rd Batt, Mb 2/3/5 Raa-Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interv   |          |
| Medical<br>Examiner   | i              | failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  | id       |
|   | Ļ              | Sequentially list conditions,  b.  | _        |
|   | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Ulsease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  | _        |
| executed an and all - transit   | ह              | d. UNPENDED AMENDED  | -        |
| 760, icate be physicia the buria  | an/Medi        | IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the   | $\neg$   |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial. | Physician      | 25b. Was decedent pregnant if the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown  9 Unknown   |          |
| P.O.  | δ              | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  | n        |
| Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been si led in by the funeral director, page 2 should be   | Completed      | 24a. Was an autopsy findings availab prior to completion of cause or death?  |          |
| al Rein: Th   | Be Co          | 25. Was case referred to medical examiner?   |          |
| of Vit<br>g Physic<br>fter this   | P              | 1 Ves 2 No location 12 Inpatient 2 ER/Outpatient 3 DOA location 4 Nursing Home 5 Residence 6 Other:  27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred  | -        |
| Sion (death.  | ation          | 1 Natural 5 Pending Aug 13, 2007 Pending 1 Yes 2 № No Pedestrian struck by auto  |          |
| Division of Vi<br>Hospital or Attending Physis<br>24 hours after death.<br>Funeral Director: After this<br>reely filled in by the funeral dir   | Certification: | Suicide 6 Could not be determined (Specify) Local Street (Specify) Local Street (28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 1700 Block E. North Avenue, Baltimore, MD  | ty       |
| To the Hosp<br>within 24 ho<br>To the Fune<br>completely fi   | Medical C      | 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |          |
| F 3 F 5   | ž              | 29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  August 14, 2007   |          |
|   |                | 30. Name and address of person who completed cause of death (Item 23a)   | $\dashv$ |
| C   | ate            | Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year) 7 117 Penistra's Signature  | $\dashv$ |
| Regist  | rar            | 31. Date filed (Month, Day, Ygar) 2007 33. Begistrar's Signeture   | $\sqcup$ |

|                                     |  | -              | For<br>State  | State               | of Maryla                         |   | rtment of F<br>tificate of             |                           | •                  | /5 /              | 1 53 57        | 00007  |
|-------------------------------------|--|----------------|---|---------------------|-----------------------------------|---|--|---------------------------|--------------------|-------------------|----------------|--|
|                                     |  |                | Registrar  1. Decedent's Name (First, Middle  | (act)               |                                   |   | incate or                              | Death                     | 2. Date of De      | Reg. No.          |                | 3. Time of Death                                 |
| 3.                                  | Physicia   | an             | 1. Decedent's Name (First, Middle   | , Lasty             |                                   |   |  |                           | Month              | Day               | Year           | 1: 20pm  |
| 7 A                                 | /Medic   | al             | Guy Avery   |                     | ()                                |   | Ab City Toyan a                        | r Location of Death       | HUGUST             |                   | ty of Death    | 1. 20/   |
| 1                                   | Examin   | er             | 4a. Facility Name (If not institution   |                     |                                   |   | 4b. City, Town, 0                      |                           |                    | 40.000            | iy of Death    |  |
|                                     | . Š  | 400            | Union Memorial  5. Social Security Number   | 6. Sex              |                                   | rs. last birthday)                                    | If Under 1 Year                        | Baltimor If Under 24 Hrs. | 8 Date of Bir      | th                | 9 Birthr       | place (State or Foreign                          |
|                                     | Funeral  |                |   | 1 <b>⊠</b> M 2□F    | 68                                |   | Months Days                            | Hours Min.                | (Month, Da         | y, Year)          | Cour           | ntry)  |
| is .                                | Director   |                | Usual Residence of Decedent   |                     | 00                                |   |  |                           | 02/2               | 0/1939            | NY             |  |
|                                     | land<br>5w   |                | 10a. State 10b. County  |                     | 10c.                              | City, Town or Lo                                      | cation                                 |                           |                    |                   | 1              | 0d. Inside City Limits                           |
|                                     | Mary<br>f sho<br>ied a   | jo             | MD Balti  | imore Cit           | B                                 | altimor   | _                                      |                           |                    |                   |                | Yes 2 □ No                                       |
|                                     | the 28a  | Director       | 10e. Street and Number  | rmore cr            | <u>.y</u>                         | ar crmor  | 10f. Zip Code                          |                           |                    | 10g. Citizen o    | f What Cour    | ntry?  |
|                                     | with yall  |                | 116 IInimomoitus  | Dlane               |                                   |   | 21210                                  |                           |                    | USA               |                |  |
|                                     | be filed within 72 hours after death with the Maryland<br>ital Hygiene.<br>id other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notified at  | Funeral        | 116 University 11. Marital Status   | 12. Was De          | ecedent Ever in                   | U.S. 13.  | Was Decedent of H                      | lispanic Origin? (S       | pecify Yes or No   | - 14. R           | ace - Americ   |  |
|                                     | r iter   | Fur            | 1 ☐ Never Married 2 ☐ Marr  |                     | Forces?<br>s 2 ☐ No<br>Give \     | 1   | f Yes, specify Cub                     | -                         | to Hican, etc.)    |                   | lack, White,   | etc.   |
| 93                                  | urs a<br>al", o<br>Exan  | by             | 3 ☐ Widowed 4 ☐ ivorced   | If Yes, o           | Dates:                            | man   | 1 ☐ Yes 2 🖂 🗓 o                        | Specify:                  |                    | Spec              | Whi            | te   |
| 5-003                               | 2 hor  | Completed      | 15. Deceden   |                     |                                   | 16a, Dece   | dent's Usual Occup                     | ation                     | rkina              | 16b. Kind of      | Business/In    | dustry   |
| 7                                   | filed within 72<br>Hygiene.<br>wher than "na<br>snt, the Medic   | ple            | (Specify only higher<br>Elementary/Secondary (0-12)   | <del>-</del>        | e (1-4or 5+)                      | life.   | DO NOT use retire                      | d)                        | iking              | State             | of Ma          | aryland  |
| 2121                                | d wit<br>giene<br>grtha<br>the   | or             |   |                     | 5+                                | Admi  | nistrativ                              | re Law Ju                 | idge               |                   |                |  |
|                                     | e filed<br>al Hygie<br>other<br>vent, th   | Be (           | 17. Father's Name (First, Middle,   | Last)               |                                   |   |  | 18. Mother's Nar          | me (First, Middle  | , Maiden Surn     | ame)           |  |
| <u>a</u>                            |  | To             | Guy Avery, Sr.  |                     |                                   |   |  | Mary U                    | nknown             |                   |                |  |
| aryland                             | s 1 and 2 should<br>f Health and Mer<br>item 27 is marke<br>other traumatic  | .              | 19a. Informant's Name/Relations   | hip (Type. Print)   |                                   | 19b. Mailir   | ng Address (Street                     | and Number or Re          | ural Route Numb    | er, City or Tow   | ın, State, Zip | o Code)  |
| Σ                                   | rt 2 mg  |                | Shannon Avery/D   | aughter             |                                   |   | Beech A                                |                           |                    |                   |                |  |
| ore                                 | es 1 a   |                | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation   | 0 □Demoval fro      | m State                           | <ol> <li>Place of Dispo<br/>cemetery, crei</li> </ol> | sition (Name of<br>matory or other pla | ce)                       | Aug 13             | 20c. Location     | n - City or To | own, State                                       |
| Ĕ                                   | Pages<br>nent of I<br>ant; If ite<br>ary or o  |                | 4 □ Donation 5 □ Other (S   |                     |                                   | Chesapea  | ke Crema                               | tory Inc                  | . 2007             | Beltsv            | ille,          | Maryland   |
| altimore,                           | permit. Pag<br>Department<br>Important; I<br>any Injury o  | li             | 21. Signature of Funeral Service  | Licensee Mo         | 1443                              | 22  | 2. Name and Addre                      | ess of Facility           |                    |                   |                |  |
| m                                   | on in the  | ja - ya        | Linda Die   | Retter              | 1945                              |   | Cremation<br>3717 Green                |                           |                    |                   | re. Mai        | ryland 21286-                                    |
|                                     |  |                | 23a. Part1. Enter the disease, or shock, or heart failure. List   | complications tha   | at caused the de                  |   |  |                           |                    |                   |                | Approximate<br>Interval Between                  |
|                                     | Physician  | 1              | Immediate Cause (Final  | only one oddoe of   | ^                                 | intes   |  | olerdine                  |                    |                   |                | Onset and Death                                  |
| 1                                   | /Medical   |                | disease or condition<br>resulting in death)   | aDue                | to (or as a cons                  |   | 17~61                                  | DICTORING                 | )                  |                   | -              | 3 days   |
|                                     | Examiner   |                |   |                     | Cirnl                             | Lizar   |  |                           |                    |                   |                | one year   |
| ą.                                  |  | Je.            | Sequentially list conditions,   | Due 1               | to (or as a cons                  | sequence of):   |  |                           |                    |                   |                |  |
| J                                   | cuted<br>d<br>ansit  | Examiner       | Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events | a i                 | tepati                            | his C   |  |                           |                    |                   |                | 3 yeurs  |
| o<br>O                              | an an<br>rial-tr   |                | resulting in death) Last  | Due                 | to (or as a cons                  | sequence of):   |  |                           |                    |                   |                | 1  |
| 8760,                               | te be<br>ysicia<br>ne bu   | dical          |   | d                   |                                   |   |  |                           |                    |                   |                |  |
| 9                                   | rtifica<br>ng ph<br>as th  | Med            | I F F F M M F   |                     |                                   |   |  |                           |                    | 10000             |                |  |
| ŏ                                   | th cer<br>endir  | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant  |                     | outcome pf pre                    |   | ∃Ectopic pregnanc                      | v                         |                    |                   | Date of deliv  |  |
| m                                   | deat<br>e atte   | icie           | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  |                     | egnant at time o                  |   | Other (specify)                        | ,                         |                    |                   | Month          | Day Year   |
| Ö                                   | tt the<br>by th  | hys            | 9 Unknown   | 913011              | KIIOWII                           |   |  |                           |                    |                   |                |  |
| S, F                                | gned<br>e de   | ру Р           | Part II. Other significant condition  | ons contributing to | death but not                     | resulting in the u                                    | <b>b</b>                               | ven in Part I.            | 23e. Did           | tobacco use co    |                | the cause of death?                              |
| ğ                                   | quire<br>en siç<br>uld b   | pa pa          | Hypertusion   | , Caro-             | ary a                             | rtery   | disease                                | WILL                      | 1 🗆                | Yes 2□ No         | 3 ☐ Pro        | babiy 4 Unknown                                  |
| Division or Vital Records, P.O. Box | aw re<br>s bee   | Completed      | cormany ant   | ery by              | puss 5                            | urger   | ¥                                      |                           | 24a. Was           |                   |                | opsy findings available<br>empletion of cause of |
| R                                   | The la   | E O            |   | 1-1                 | ( -                               | J   |  |                           | auto<br>perf       | ormed?∕<br>2 ☑ No | death?         | 2 No   |
| tal                                 | an: ]<br>tificat   |                | 25. Was case referred to medica   |                     |                                   |   |  | 26. Place of De           | ath (Check only    |                   | 1 1 1 1 1 1 1  | 22110  |
| >                                   | /sich  | To Be          | examiner?<br>1 ☐ Yes 2 ☑ No   | Hospital: 1         | Inpatient 2                       | P ☐ ER/Outpatie                                       | nt 3 DOA Ott                           | ner: 4 🗆 Nursing I        | Home 5□Res         | idence 6 □0       | Other (Speci   | fy)  |
| ō                                   | g Ph<br>er thi   |                | 27. Manner of Death   | /8/                 | ate of Injury<br>Sonth, Day Year  | 28b. Time o   | f 28c. Inju                            | ry at                     |                    | how injury occ    | <del></del>    |  |
| o                                   | nding<br>th.<br>; Afte   | 텵              | 1 Natural 5 Pendir<br>2 Accident investi  | 9                   | юпіп, Day теаг                    | r) Injury   | I                                      | Yes 2 □ No                |                    |                   |                |  |
| Vis                                 | Atter<br>r dea<br>ector<br>by th   | iic            | 3 Suicide 6 Could<br>4 Homicide determ  | inod   200, F18     | ace of injury - A                 | t home, farm, st                                      | reet, factory, office                  |                           | 28f. Location      | (Street and Nu    | mber or Rur    | al Route Number,                                 |
| ă                                   | al or<br>afte<br>I Dir   | Certification: | 4   Homoide   |                     | inding, etc. (3p                  | sury)   |  |                           | Oily of To         | wii, State)       |                |  |
|                                     | spita<br>hours<br>inera<br>y fille   |                |   |                     |                                   |   | h occurred at the t                    |                           |                    |                   |                |  |
|                                     | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit   | Medical        | (Check only 2 Medical one)  |                     | e basis of exam<br>nanner stated. | ilitation and/of if                                   | ivestigation, in my                    | оринон, аеатп осс         | Jurred at the time | , date and plac   | e, and due     | to trie cause(s)                                 |
|                                     | To the To the To the Complex C | ž              | 29b. Signature and title of certifie  |                     |                                   |   | 29c. Licen                             |                           | ~                  | 29d. Date sig     |                | , Day, Year)                                     |
|                                     |  |                | Stul  | mus T               | The s                             | <b>)</b> ,  | DC                                     | 06311                     | که                 | Augusi            | + 11,          | 2007   |
| ,                                   | 521  |                | 30. Name and address of person  | who completed c     | ause of death (                   | Item 23a) (Type,                                      | Print)                                 | _                         |                    |                   | ,              | *  |
| ,                                   | )  |                | Stephen Nguyen,   | M.D. Z              | OI Ecit                           | Univers   | Print) Park                            | Ly Belt                   | were p             | ID 21             | 218            |  |
|                                     | ≅ Sta  | ate            | 31. Date filed (Month, Day, Year,   |                     | 2. Registrar's Si                 |   |  |                           |                    |                   |                |  |
|                                     | Regist   | rar            | AUC 1   | 5 2007              |                                   | 8.0   | 2                                      |                           |                    |                   |                |  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007-26098 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year 7 **Physician** Day 2:4L, AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Town, or Location of Death BALTIMORE CON SAMARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 ☐ F 65 Director 217-38-3535 March 12,1942 Virginia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Director 1XYes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural" or items 23a Funeral 4503 Schley Avenue 21206 U. S. A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify ð 3 X Widowed 4 ☐ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Cemeterv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev ျှ John J. Aleshire Edna P. Duncan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Aleshire (Brother) 4503 Schley Ave., Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 08/09/2007 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the se se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fair e. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2□No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Tyes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [ 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NARIL ZEINEH, GOD SAMARITAN HOSPITAL, SED LOCH RAVEN Blud, 21739 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007-26099 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5:15 AM M 2007 Norma Marie Appold 08 13 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Funeral 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☐ M 2 🛛 F Director 220-94-6138 85 02/26/1922 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 8369 Tapu Court 21236 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ 3 XWidowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 School Teacher Baltimore Cit Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked Walter Mueller Olive Shumaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: if Item 27 Is any injury or other trau <u>Andrea D. Beecher (daughter)</u> 5728 Allender Road - White Marsh, Maryland 21162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🔀 Removal from State 4 Donation 5 Dother (Specify) Camp Hill Cemetery | 08/17/2007 Paw Paw, West Virginia 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licenses assala 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE CARDIOMYOPATHY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of). physician a s the burial-P.O. Box 68760 Physician/Medical attending pl IF FFMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😿 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide in by Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 5 2007

Registrar's Signature

|                            |   |                | State of Maryland / Department of Health and Mental Hygiene  1 - For State Registrar  Certificate of Death  Reg. No.   | 26100   |
|----------------------------|---|----------------|--|---|
| * 4                        | Physici<br>/Medic   |                | 1. Decadent's Name (First, Middle, Last)  Alford  2. Date of Death August 6, 200   | 7 4:40 PM                                     |
|                            | Examir<br>Funeral   | er             | 5. Social Security Number 6. Sex 7. Age (In yrs. left birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9.1  | Birthplace (State or Foreign                  |
|                            | Director  |                | Q12-18-8914 1 M 2 F 85 Yrs. Months Days Hours Min. June 5, 1923  | Cauntry)  Ary and  10d. Inside City Limits    |
|                            | the Maryls<br>28a-f sho   | Director       |  | 1 Nes 2 No                                    |
|                            | death with<br>ms 23e or<br>r nam be   | Funeral DI     | 18 00 Hollins Street 2 12. Was Decedent Ever in U.S. Armed Forces 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Armed Forces 14. Race - A Black, W  | merican Indian,                               |
| 0036                       | hours after<br>urel', or its  | d by Fu        | 1 Never Married 2 Marned 1 Yes 2 No If Yes, Give Year or Dates:  1 Never Married 2 Marned I Yes 2 No Specify: Specify: Specify:  | Hite, etc.                                    |
| 21215-0036                 | tiled within 72 hours after death with the Maryland<br>Hyglene.<br>ther than "naturel", or items 23a or 28a-f show<br>ant, the Medical Examination multiple multified at  | Completed by   | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  LAUN  | dru   |
| Maryland 2                 | should be filed<br>nd Mental Hyg<br>r marked othe<br>umatic event,  | To Be C        | 17. Eather's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  18. Mother's Name (First, Middle, Maiden Sumame)  | 3   |
|                            | 1 and 2 sho<br>Health and<br>Im 27 Is mu  |                | 19a. Informant's Name/Relationship (Type, Print) Date 19b. Mailing Address (Street and Number, r Rural Route Number, City or Town, State 5 Date 20. Location - City 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20. Location - City 20a. Method of Disposition (Name of Date 20a. Location - City 20a. Method of Disposition (Name of Date 20a. Location - City 20a. Method of Disposition (Name of Date 20a. Location - City 20a. Method of Disposition (Name of Date 20a. Location - City 20a. Method of Disposition (Name of Date 20a. Location - City 20a. Method of Disposition (Name of Date 20a. Location - City 20a. Method of Disposition (Name of Date 20a. Location - City 20a. Method of Disposition (Name of Date 20a. Location - City 20a. Method of Date 20a. Method of Date 20a. Location - City 20a. Method of Date 20a. Location - City 20a. Method of Date 20a. Method of Date 20a. Location - City 20a. Method of Date 20a. Method 20a. Meth | 21205   |
| Baltimore,                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examination at any injury. |                | 20a. Method of Disposition  1 © Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licents  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)  | m Mary land                                   |
| Ba                         | permit. Departr Imports eny inje  |                | 23a. Part 1. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   | Approximate                                   |
| 200                        | Physician<br>/Medical   |                | shock, if heart faiture. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Calduc Structure Cause (Final disease or condition resulting in death)   | Interval Between<br>Onset and Death           |
|                            | Examiner  | lner           | Sequentially list conditions, if any, leading to immediate cause. Enter Undertrying Cause (Disease or injury   |   |
| 8760,                      | cate be executed<br>physicien and<br>the burial-transit   | dical Examiner | resulting in death) Last Due to (or as a consequence of):  |   |
| Box 687                    | leath certificate<br>attending phys<br>I for use as the   | n/Medic        | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of   | delivery                                      |
| P.O. B                     | res that the death certigned by the attendin<br>be detached for use   | Physician/Med  | in the past 12 months? 1 ☐ Ive birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Yes 2 ☐ Mo 9 ☐ Unknown  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐ Month  | Day Year                                      |
|                            | The law requires that the death certific<br>sie has been signed by the atlending p<br>page 2 should be detached for use as  | þ              | Part II. Other significant conditions continuously to death but not resulting in the underlying cause given in Part I.   | e to the cause of death?  Probably 4 □Unknown |
| Division of Vital Records, | rsician: The law<br>s certificate has b<br>director, page 2 sl  | Completed      |  |   |
| of Vit                     | g Physiciar<br>ar this certif<br>eral directo   | n; To Be       | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (S  | pecify)                                       |
| ivision                    | r Attendinger death.  | Certification; | Natural 5 Pending investigation  3 Suicide 6 Could not be determined 4 Homicide 4 Homicide (Month, Day Year) Injury Work?  1 Yes 2 No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or City or Town, State)  | Rural Route Number,                           |
| ۵                          | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page  | edical Cer     |  | as stated.<br>due to the cause(s)             |
| )                          | To the within 2 To the comple   | Med            | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mc   | onth, Day, Year)                              |
|                            | 3   |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), #308, Baltimore, MD  | 21201   |
|                            | Sta<br>Registr  |                | 3 Daly med (Month, Day, Year)  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 1550 PM JEAN AUGUST 13 2007 BARBARA ADAMS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HULP IT AZ BALTIMORE NORTH WEST RANDAULS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex last birthday) 7. Age (In vrs. **Funeral** Days 1 ☐ M 2 N F Months Hours Min. 64 Director Usual Residence of Decedent Town or Location 10a. State 10h. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD ikesville 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 21208 Silver by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 □ Widowed 4 □ Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT one patred) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) me (First, Middle, Maiden Surname, Be 19b. Mailing Address (Street and Number or Rural Route Number, C ty or Town, State, Zip Code) Kesville, MD 21208 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 ☐ Cremation Woodlawn, mD 3 ☐Removal from State 8-18-07 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens more Nat'l P.ICE, Batto, MD 21229 (0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** antrounteetune /Medical Due to (a as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the ceuse of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☒ No 24a. Was an certificate has page 2 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1. Inpatient 2 ER/Outpatient 3 DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ano 20059736 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FITZPATRICK NURTHWEST WATS HOSPITAL INO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Dolores A. Agro August 2007 11:20 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1006 - 1st Street Anne Arundel Glen Burnie If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛱 F 88 Director Yrs 216 03 8506 Jan. 11. Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic avent, the Modical Extratribut roust be retified at Maryland Anne Arundel Glen Burnie 1 Yes 2X No Directo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1006 First Street 21060 U.S.A. Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7. h and Mental Hygiene. 7 is marked othar than "ns Elementary/Secondary (0-12) College (1-4or 5+) Office Worker Fleet Transfer 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin Sill Marie Fetchbeck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 is n any injury or other traum Rosemary Schmidt / Daughter 1720 Furnace Drive Glen Burnie, Maryland 21060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🙀 Buriai 2 □ Cremation 3 □ Removal from State Sacred Heart of Jesus 8/11/2007 Baltimore, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Vascul Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Tensia Sequentially list conditions. Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of) The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): Box 68760. nding physician Physician/Medical IF FEMALE: nse : 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery atter 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy į in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year Month 4☐Pregnant at time of death 5 Other (specify) P.O. | the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sh 24a. Was an autopsy performed2 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attanding Physicien: director 25. Was case referred to medical Be 26. Place of Death Check onl. one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 2 Accident investigation 1 Yes 2 No Diractor: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hou. The Funaral Dirac. 4 - Homicide 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Dav. Year) 34109 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint) PASADENA 0 lichae 31. Date filed (Month Day , Vear) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2007 Aileen 10 N. August Beggs 11:00 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1799 Montreal Rd. Severn Anne Arundel If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Mar. 29, 1 5. Social Security Number Birthplace (State or Foreign Country) 6 Say 7. Age (In yrs. last birthday) 1 □ M 2 X F 397-42-5560 93 1914 Wisconcin Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Severn 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1799 Montreal Rd. 21144 United States 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John J. Noonan Mary Jane Herald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Beggs / Daughter 1799 Montreal Rd., Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State August 17, 1 ☐ Berial 2 ☐ Cremation 3 🖾 Removal from State Clintonville, WI Graceland Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, 21. Signatur of Huckral Service License 0 MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (3) as a consequence of): minites Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Veat 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? No No 1 TYes 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

þ

Completed

Be

2

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

id 2 should be filed within 72 hours after death with the Marylan th and Mental Hygiene. 27 is marked other than "natural", or liems 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should I

nt of Health a :: If item 27 is r or other tra

permit. Page Department of Important: If any Injury or

The law requires that the death certificate be executed and

use

for

page 2

director,

Certification: To

Medical

certificate I

this

After

Physician:

Hospital or Attending

death.

hin 24 hours after death the Funeral Director;

within To the

filled in by

completely

Examiner Physician/Medical à Completed 25. Was case referred to medical examiner? Be

IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No

and manner stated.

24a. Was an

autopsy 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

1 🔲 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1 ☐ Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only

4 ☐ Homicide

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

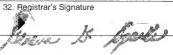
Hospital:

Loraine M. Dailey, M.D., 8098 Edwin Raynor Blvd., Pasadena, Maryland 21122

State Registrar

5 Pending investigation

6 ☐ Could not be



|                   |  |                |   | State of                                   | of Marylan  |                                  |                                   |                           |  |               | •                                    |                       | 9   |   |                      |
|-------------------|--|----------------|---|--|---|----------------------------------|-----------------------------------|---------------------------|--|---------------|--------------------------------------|-----------------------|---|---|----------------------|
|                   |  |                | For State Registrar   |  | •   |                                  |                                   |                           | Death                                  |               |                                      | Reg. No               | 2000                                      | 26                                      | 01                   |
|                   |  |                | 1. Decedent's Name (First, Middl  | e, Last)                                   |   | -                                |                                   |                           |  |               | 2. Date of D                         | eath<br>Da            | ay Year                                   | 3. Time of                              | Death                |
|                   | Physici<br>/Medic  |                | WILBERT HENRY   | BALL                                       |   |                                  |                                   |                           |  |               | August                               |                       |   | 5:15                                    | $\mathtt{P}^{M}$     |
|                   | Examin   |                | 4a. Facility Name (If not institution   | n, give street and nu                      | mber)   |                                  | 4b. City                          | , Town, or                | Location of                            | of Death      |                                      | 40                    | . County of Dea                           | th                                      |                      |
|                   |  | <b>20</b>      | JOSEPH RICHIE   | HOSPICE                                    |   |                                  |                                   | BALTI                     |  |               |                                      |                       |   |   |                      |
| j.,               | Funeral<br>Director  |                | 5. Social Security Number 226-32-0931   | 6. Sex<br>1 □ XM 2 □ F                     | 7. Age (In yrs. 76  | las <i>t birthday)</i><br>Yrs.   | If Unde<br>Months                 | Days                      | If Under<br>Hours                      | Min.          | 8. Date of Bi<br>(Month, D<br>Januar | ay, Year              | 9. Bir<br>Cc<br>3, 1931                   | thplace (State of<br>ountry)<br>Marylai | _                    |
|                   | yłand<br>now<br>at   |                | Usual Residence of Decedent  10a. State 10b. County   | · · · ·                                    | 10c. Cit  | y, Town or Lo                    | cation                            |                           |  |               |                                      |                       |   | 10d. Inside Cit                         | ty Limits            |
|                   | a-f sl   | Director       | MD  |  |   | BALTIM                           | ORE                               |                           |  |               |                                      |                       |   | 1 X Yes                                 | 2 □ No               |
|                   | or 28  | Jire           | 10e. Street and Number  |  |   |                                  | 10f. Zi                           | p Code                    |  |               |                                      | 10g. C                | tizen of What Co                          | ountry?                                 |                      |
|                   | 23a<br>ust b   |                | 427 ROBERT ST.  |  |   |                                  |                                   | 2                         | 1217                                   |               |                                      | U.S                   | .A.                                       |   |                      |
| 36                | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by Funeral     | 11. Marital Status  1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced  | Armed For                                  | 2 □ No  |                                  | Was Dece<br>If Yes, sp<br>1 □ Yes |                           | ispanic Ori<br>an, Mexical<br>Specify: |               | cify Yes or N<br>Rican, etc.)        | 0-                    | 14. Race - Ame<br>Black, Whit<br>Specify: |   |                      |
| 5-0036            | hour<br>tural  | pe pe          |   | nt's Education                             | Dates: 1951   | -1953<br>16a. Dece               | dont's He                         | ual Occup                 | ation                                  |               |                                      | 16b I                 | B<br>Kind of Business                     | LACK                                    |                      |
| 21215-            | within 72<br>iene.<br>than "na<br>he Medic   | Completed      | (Specify only higher Elementary/Secondary (0-12) 8th  | est grade completed)  College (            | 1-4or 5+)   | (Give<br>life.                   | kind of w<br>DO NOT               | ork done d<br>use retired | during mos<br>f)                       | st of workir  | g                                    |                       | NSTRUCT                                   |   |                      |
| d 2               | filed<br>Hygi<br>other   | Ö              | 17. Father's Name (First, Middle,   | Last)                                      |   |                                  | OKLIM                             | -71/                      | 18. Mothe                              | er's Name     | (First, Middle                       | _                     |   | ION                                     |                      |
| Maryland          | 12 should be filed w<br>n and Mental Hygie<br>Is marked other ti<br>raumatic event, th   | To Be          | ARVIBES DAVIS   |  |   |                                  |                                   |                           | EDIT                                   | TH BA         | LL PRI                               | NCE                   |   |   |                      |
| lar)              | 2 sho<br>and t<br>Is ma  |                | 19a. Informant's Name/Relations   |  |   |                                  |                                   |                           |  |               |                                      |                       | or Town, State,                           | ,                                       |                      |
|                   | 1 and 2<br>Health<br>tem 27 I  |                | JACQUELINE BAL  | L/WIFE                                     |   |                                  |                                   |                           | . BAI                                  |               |                                      |                       | ND 2121                                   |   |                      |
| ore               | Pages 1<br>nent of H<br>int: If Iter<br>iry or oth   |                | 20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation   | 3 ☐ Removal from                           |   | Place of Dispo<br>emetery, crea  | sition (Na<br>matory or           | ame of<br>other plac      | :е)                                    | D             | ate                                  | 20c. L                | ocation - City or                         | Town, State                             |                      |
| Ë                 | tmen<br>tant:  |                | 4 □ Donation 5 □ Other (5   | Specify)                                   |   | rison                            |                                   |                           |  | 8/16/         | 07                                   | Owi                   | ngs Mil                                   | ls, MD                                  |                      |
| Baltimore,        | permit. Pages 1 an<br>Department of Heal<br>Important: If Item 2<br>any Injury or other<br>once.   |                | 21. Signature of Funeral Service  |  |   | W                                | illia<br>206 T                    | am C.<br>N. No            | rth A                                  | wn CO<br>Ave. | Baltim                               | iore,                 | Ineral H<br>MD 212                        |   | •                    |
|                   | Physician  |                | 282 Part 1. Enter the disease, o<br>shock, or heart failure. List<br>immediate Cause (Final<br>disease or condition               | r complications that<br>tonly one cause on | caused the deat<br>each line.                                   | h. Do not ent                    | ter the mo                        | de of dyin                | ig, such as                            | s cardiac o   | r respiratory                        | arrest,               |   | Approximate Interval Bette Onset and I  | ween<br>Death        |
|                   | /Medical<br>Examiner   |                | resulting in death)   | Due to                                     | (or as a conseq   | uence of):                       |                                   |                           |  |               |                                      |                       |   |   | -                    |
|                   | uted<br>d<br>ansit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Due to                                  | (or as a conseq   | uence of):                       |                                   |                           |  |               |                                      |                       |   |   |                      |
| ,092              | death certificate be executed<br>e attending physician and<br>d for use as the burial-transit  | cal            | resulting in death) Last  | Due to                                     | (or as a conseq   | uence of):                       |                                   |                           |  |               |                                      |                       |   |   |                      |
| 68                | rtificar<br>ng ph<br>as th   | <b>ledi</b>    | IF FELLUS   |  |   |                                  |                                   |                           |  |               |                                      |                       |   |   |                      |
| .O. Box           | that the death certificate led by the attending physic detached for use as the b   | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 1 ☐ Live                                   | itcome pf pregna<br>birth 2 □ Feta<br>nant at time of c<br>nown | ıl death 3 [                     | □Ectopic  <br>□ Other (s          | pregnancy<br>specify)     | ′                                      |               |                                      |                       | 23d. Date of de<br>Month                  |   | Year'                |
| <u>α</u>          | that the ed by detac   |                | Part II. Other significant conditi  | ons contributing to o                      | leath but not res   | ulting in the u                  | nderlying                         | cause give                | en in Part I                           | I.            | 23e. Did                             | tobacco               | use contribute t                          | o the cause of d                        | leath?               |
| or Vital Records, | sign<br>sign   | ed by          | TZDM  |  |   |                                  |                                   |                           |  |               | 1 🗆                                  | ] Yes                 | 21 No 3□P                                 | robably 4 🗆 L                           | Jnknown              |
| eco               | e law requ<br>has been<br>je 2 shoulk  | Completed      | HTN   |  |   |                                  |                                   |                           |  |               | 24a. Wa                              | s an<br>opsy          | 24b. Were a                               | utopsy findings a<br>completion of ca   | available<br>ause of |
| H                 |  | Con            | Dement  | a ·  |   |                                  |                                   |                           |  |               | per<br>1□ Yes                        | formed?               | death?                                    |   |                      |
| Vita              | slcian: Th<br>certificate<br>rector, pag   | Be             | 25. Was case referred to medica examiner?   |  |   |                                  |                                   | 0,1                       |  | e of Death    | (Check only                          | one)                  |   |   |                      |
| or                | di is  | 은              | 1 ☐ Yes 2 No  27. Manner of Death   |  | Inpatient 2   |                                  |                                   |                           | 4 🗆 N                                  |               | ne 5 Re                              |                       | 6 Sother (Spe                             | ecify) HOT                              | Dice.                |
|                   | Ing<br>After<br>une  | ation:         | 1 Natural 5 Pendir<br>2 Accident Investi  | '9   | oth, Day Year)  | 28b. Time o<br>Injury            | М                                 | 28c. Injur<br>Worl<br>1 □ | yaτ<br>k?<br>Yes 2□                    |               | 8d. Describe                         | e how inj             | ury occurred                              |   |                      |
| Division          | e train  | Certification: | 3 Suicide 6 Could<br>4 Homicide determ  | nined   Zoe. Place                         | e of injury - At he<br>ling, etc. (Specil                       | ome, farm, str                   | reet, facto                       | ry, office                |  | 2             | 8f. Location<br>City or To           |                       | und Number or Fi<br>te)                   | lural Route Num                         | nber,                |
|                   | Hospita<br>4 hours<br>Funeral<br>tely filled   | /ledical Ce    | 29a. Certifier 1 Certifyli<br>(Check only one) 2 Medical  | ng Physician: To th<br>Examiner: On the l  | e best of my kno<br>casis of examina                            | owledge, deat<br>ation and/or in | h occurre                         | d at the tir              | me, date a<br>ppinion, de              | ind place, a  | and due to the                       | e cause(<br>e, date a | s) and manner a<br>nd place, and du       | s stated.<br>le to the cause(s          | s)                   |
|                   | the<br>the<br>mple   | Je             | COL Circulation and Man of codific  | and mai                                    |   |                                  | 20                                | Oc Licone                 |  |               |                                      | 00   0                |   |   |                      |

State

AUG 1 5 2007 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Out (No Brown)

31. Date filed (Month; Day, Year)

32 Degistrar's Signature

420 8-12-07 Cinden A Baltinere, AD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend 20b-c, perFH, C870, 8/15/07 TT Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 08-06-2007 Day Physician 2145 George W. Buchman, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Hospital Rel Air | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) | 10-18-1932 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 **⊠** M 2 □ F Yrs. 218-28-9973 74 Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No FAllston Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2108 Hampshire Drive 21047 U.S.A. Funeral 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Be Completed by Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Materials Manager MD Speciality Wire 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George W. Buchman, Sr. Loretta Coffay 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 5874 Winter Oaks Pl. Frederick, MD 21704 George W. Buchman, III (Son) Department of Heali Important: If item 2 any Injury or other 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Ob. Place of Disposition (name of Leonetery, crematory or other place)
Highwiew Memorial Gardens
St. John S Cemetery 1 X Burial 2 □ Cremation 3 □ Removal from State Fallston, Maryland 08-10-2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Licensee Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Failure Acute Kenal Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Mellitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown page 2 should Cerebrovaseular Discase 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed? res 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

M000191309 o ے GEOUGE Hospital or Attending

Pages 1 and 2

Baltimore,

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31. Date filed (Month, Day, Year) State Registrar

Kelin

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Gode

D35012

2 North Ave Bel Air, Md. 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2007 06:33 AM 08 12 Mildred Eileen Bolch /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Air, Maryland Year | f Under 24 Hrs. | 8. p Harford Upper Chesapeake Medical Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 💢 F 11/29/1921 85 Pennsylvania Director 178-14-9201 Usual Residence of Decedent 12 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. r is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Baldwin Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21013 13320 Fork Road Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2**X** No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Edgewood Aresenal Administrator 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hilda Marie Pickell Robert Franklin Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 13320 Fork Road - Baldwin, Maryland Sandra Glock (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Highview Memorial Gdn. 08/15/2007 Fallston, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee assahn 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEVERE DEHYDRATION ONE WEEK **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learny to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine the burial-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 XNo 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 ☐ Unknowń 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 24 hours after death. Injury 5 Pending investigation Natural within 24 hours after occur.

To the Funeral Director: After the funeral by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

Baltimore, Maryland 21215-0036

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Division

Registrar

31. Date filed (Month, Day, Year) AUG 1 5 2007

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICIA GURM, ND UPPER CHESA PEAKE MEDICIAL CENTER BELL AIR MAKYLAND 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

AUGUST 12, 2007

| More   A   Feets   Name   A      | 26101                                 |
|--|---------------------------------------|
| 8800 WaltherBlvd. Apt. 4516  Function  Function  Fig. 1 Under 2 Hrs.   | Z 10 AM                               |
| 10a State   10b County   10c City, Town or Location   10d City, Town or    | e (State or Foreign                   |
| Esther M. Balles (Wife)  20a. Method of Disposition  1   | Inside City Limits 1 ☐ Yes 2√XNo      |
| Esther M. Balles (Wife)  20a. Method of Disposition  1   | · ·                                   |
| Esther M. Balles (Wife)  20a. Method of Disposition  1   |                                       |
| Physician /Medical Examiner  Due to (or as a consequence of):   |                                       |
| Physician /Medical Examiner  Due to (or as a consequence of):   | State                                 |
| Physician /Medical Examiner  Immediate Ceuse (Final disease or condition resulting in death)  Due to (or as a consequence of):   |                                       |
| Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):   | proximate erval Between set and Death |
| Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I.    Part II. Other eignificent conditions contribute to the specific compile of the property of the part of the property of the part o |                                       |
| 24a. Was en eutopsy performed?  24a. Was en eutopsy performed?  24b. Were eveille complication of deal performed?  25c. Was case referred to medical examiner?  1  | cause of death?                       |
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| 27. Magne of Death  1 Netural  28d. Describe how injury occurred  Work?  1 Netural  2 No determined  28d. Describe how injury occurred  Work?  1 No determined  28d. Describe how injury occurred  Work?  1 No determined  28d. Describe how injury occurred  Work?  28d. Injury et  Work?  1 No determined  Work?  28d. Injury et  Work?  1 No determined  Work?  28d. Describe how injury occurred  28d. Describe how injury occurred  Work?  28d. Describe how injury occurred  | ıte Number,                           |
| 29a. Certifier (Check only one)   | cause(s)                              |
| DI3111 August 10th   | Year) 2007                            |
| 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)  The London No. 8 500 Walth Black Particle MD 2123  State  31. Date filed (Month, Day, Year)  32. Registral & Signature   | 1                                     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11:15 AM AUGVET Mildred L. Bradley 10 2007 4c. County of Death 4a. Fagility Name (If not institution, give street and number) 4h. Citv. Town, or Location of Death AGMES HOSPITAL CIENTORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours 1□ M 2□ F 217-24-2664 Oct 25, 1931 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Kes 2 No Baltimore N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 U.S.A. 905 Warwick Avenue 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ **X**o Specify. Specify. Black 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Administration Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary W. Warren **Emmitt Warren** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8788 Stonehouse Drive Ellicott City, Maryland 21043 Lydia Robinson Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Rurial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Md. 08/17/07 4 Donation 5 Other (Specify) Garrison Forest Veterans Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ORONARY lo DAYS Due to (or as a consequence of): Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a nonsequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown RENAL DESEASE, MUNTPLE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No HYPERTENSPON 24a. Was an INFARLECON. MYOCARDIAL performed JELZURE 2 No DESCROER 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Vo 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

be executed and attending physician for use as the buris P.O. Records, MILLBR page 2 certificate Vital o BRADLE Division the Hospital or Attending

Director: within 24 hours after To the Funeral Dictornal Completely filled in

Physician/Medical δ Completed Be ၉ Certification:

29a, Certifier

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Physician

/Medical

**Examiner** 

**Funeral** 

Director

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**Physician** 

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Examiner

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

State Registrar

Medical

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

21227

BACTEMORE

AUG UST 2007 10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

St AGNES HOSPETAL

giştrar's Signature

and manner stated.

31. Date filed (Month, Day, Year) 7



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, state Registrar Amend 26, perMD, g870, 8/15/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 1:30 a M VIRGINIA LEE BANDTHOLTZ 2007 August 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Apt. 2 West Baltimore 4606 Ridge Avenue Halethorpe 8. Date of Birth (Month, Day, Year) Nov. 11,1932 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 □ X Months Days Maryland Director 212-30-6832 74 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner missing the once. 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7748 Meadow Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: þ 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 N/A Secretary Monarch Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harlan McCrearey ပ Dorcas Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie L. Fridley (Daughter) 4606 Ridge Ave. Apt 2 West Halethorpe Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/15/07 Glen Haven Mem. Pk. Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 Mins 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a con equence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1☐ Yes 2☐ No 9☐ Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes Be 25. Was case referred to medical examiner? Daughter's Home 26. Place of Death (Check only one) 1 Yes Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 1 Other (Specify) Certification: To 27. Manner of De 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 8 D21613 9

DHMH 17 Rev 1/2001

Registrar

Magothy Beach Road, Pasadena, Maryland 21122

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M D

Loraine M. Dailey

31. Date filed (Month, Day, Year)

07-06077

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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|-------------------|--|----------------|--|---|---|--------------------------------|---|--|--|
| -1:               | Physicia   | in/            | Registrar  1. Decedent's Name (First, Middle,Last)  Dean R. Blake Jr.  |   |   | -                              | 2. Date of Death                                      | Day Year                                     | 3. Time of Death<br>0426 hrs                 |
| learn             | ai Exami   |                | 4a. Facility Name (if not institution, give street and number)   |   | 4b. City, Town, or<br>Glen Burnie           |                                |   | 4c. County of Dea                            |  |
|                   |  |                | BWMC   | In yrs. last birthday)                          | If Under 1 Yes                              |                                | 24Hrs. 8. Date of Birth                               | (MM/DD/YYYY) 9. B                            |  |
|                   | Funeral<br>Director  |                | 213-19-5933 1XM 2_F  | 23 Yr   | Months Day                                  |                                | Min   | 9, 1984 Fore                                 | ign Maryland<br>ountry)                      |
|                   | any  | T              | 7007.01010   | Oc. City, Town or Loca<br>Pasa                  |   |                                |   |  | 10d. Inside City Limits  1 Yes 2 No          |
|                   | Maryland<br>28a-f show<br>d at once.   |                |  | rasa  |   |                                | 110   | g. Citizen of What Co                        |  |
| 5                 | th the Maryland<br>23a or 28a-f sho<br>notified at once.   | Director       | 10e. Street and Number<br>8438 Maryland Road   |   | 10f. Zip Code 21122                         |                                | 14 (2)  | U.S.A.                                       |  |
|                   | Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once  | Funeral        | 11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2   | ver in U.S. 13. W                               | /as Decedent of H<br>Yes, specify Cuba      | ispanic Origi<br>n, Mexican,   | n? ( Specify Yes or No-<br>Puerto Rican, etc.)        | 14. Race - Ame<br>White, etc.<br>Whi         | erican Indian, Black,<br>te                  |
|                   | after d  | by Fi          | 3 Widowed 4 Divorced If Yes, Give Year or Dates:   | 1_  |   | o specify:                     |   | Specify:<br>16b. Kind of Busines             | o (Industry                                  |
| 1 1               | hours<br>natur:<br>Exami   | edt            | 15. Decedent's Education (Specify only highest grade comp  | during  | ent's Usual Occupa<br>most of working lif   | ation (Give k<br>e. DO NOT (   | use retired)  | 100. Nind of Busines                         | s/illustry                                   |
| 36                | in 72<br>han "<br>dical I  | Completed      | Elementary/Secondary (0-12) College (1-4 or 5+   |   | truction                                    | Worke                          | r   | Blake Con                                    | struction                                    |
| 21215-0036        | led within 72<br>Hygiene.<br>other than '  | 틍              | 17. Father's Name (First, Middle, Last)  |   |   |                                | s Name (First, Middle, M                              |  |  |
| 215               | uld be file<br>Mental H<br>marked o  | Be (           | Dean R. Blake Sr.  |   |   |                                | andra   | Jenkins                                      | ata Zin Codo)                                |
| 21                | should<br>and Me<br>7 is man   | ပ              | 19a. Informant's Name/Relationship (Type, Print)  Dean R. Blake Sr. (Father)   |   |   |                                | ber or Rural Route Num                                |  |  |
| Ĕ                 | nd 2 stalth and 27 sem 27 raums  |                | 20a. Method of Disposition   | 20b. Place of Disp                              |   |                                | , Pasadena.   | 20c. Location - City                         | or Town, State                               |
| more              | permit Pages I and 2 shou<br>Department of Health and I<br>Important: If item 27 is r<br>injury or other traumatic   |                | 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  | Gren nave                                       | en Mem. 1                                   |                                |   |  | ie, Maryland                                 |
| <u>a</u>          | rmit<br>spartm<br>iporta<br>jury o   |                | 21. Signature of Funeral Service Licensee  | / 22<br>M                                       | Name and Addre                              | ss of Facility                 | k Funeral H<br>Road, Pasad                            | Jome P.A.                                    | 1 1 01100                                    |
| _                 |  |                | 23 art I. Enter the disease, or complications that caused to   | ne death. Do not ente                           | 32U4 Mout                                   | ntain<br>a. such as c          | Koad, Pasac   | lena, Mary<br>est, shock, or heart           | Approximate interval                         |
| P                 | hysician<br>'ledical   |                | failure. List only one cause on each line.   |   |   | A                              |   |  | Between Onset and<br>Death                   |
|                   | aminer   | 0              | Immediate Cause (Final disease or condition resulting in death)  a. Head and new Due to (or as a consecutive form)       |   | campilicate                                 | i by tire                      | MILLIE  |  |  |
|                   |  | ner            | Sequentially list conditions, if any, leading to immediate Due to (or as a conse   | quence of):                                     |   |                                |   |  |  |
|                   |  | Examine        | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a conse | quence of):                                     |   |                                |   |  |  |
|                   | recuted<br>and<br>rans   | a E            | d.   |   |   | - 10-                          |   |  |  |
| _                 | e be es<br>sician<br>burial  | Medical        | #1,23d,21  | ,28a-f, perM                                    | E <b>,g</b> 870,8/2                         | 23/07 T                        | <u> </u>  | 23d. Date of deli                            | very   |
| 6876              | e death certificate be executed the attending physician and ted for use as the burial - transit  | ian/M          | 23b. Was decedent pregnant in the  | ime of death 5                                  | Fetal death Other (Specify)                 | 3 Ectopi                       | c pregnancy   | Month  | Day Year                                     |
| Š                 | e death of the atter   | Physician/     | 1 Yes 2 No 9 Unknown 9 Unknown   | •   |   |                                |   | 1  | of doub?                                     |
| -                 | ires that the de signed by the de detached f   | y P            | Part II. Other significant conditions contributing to death  | but not resulting in th                         | ne underlying caus                          | e given in Pa                  | u   |  | e to the cause of death?  Probably 4 Unknown |
| Vital Bosonde B O | uires the signe  | ed by          |  |   |   |                                | 24a. Was  |  | autopsy findings available                   |
| 7                 | w requares to the second of th | Completed      |  |   |   |                                | auto<br>perfe   | psy prior<br>ormed? deat                     |  |
| 0                 | The la   | Ę              |  |   |   |                                | 1 🗸 Yes   | 2 No 1 🗸                                     | Yes 2 No                                     |
| - =               | certifi<br>ector,  | B              | 25. Was case referred to medical   | - 2 - 4 ED/Outpot                               |   | Other                          | (Check only one)  Nursing Home 5                      | Residence 6 C                                | Other:                                       |
| 3 3               | Physic<br>Physic<br>er this  | ₽              | 1 ✓ Yes 2 No 1 Inpatte 27. Manner of Death 28a. Date of Inju   | nt 2 ER/Outpati                                 |   | njury at Wor                   |   | how injury occurred                          |  |
| NOTE OF VI        | orion<br>ading<br>th.<br>After   | Ö              | 1 Natural 5 Pending (Month, Day, Y   | 1   | am 1  | Yes 2 X                        | No subject  | jumped into                                  | pool   |
|                   | Atter Atter rector   | icat           | 28e. Place of In   | jury - At home, farm, s                         | street, factory, office                     | ce building, e                 | etc. 28f. Location                                    | (Street and Number of                        | r Rural Route Number, City                   |
| H 2               | ital or ral Dis  | Certification: |  | imming pool                                     |   |                                |   |  | Severna Park, MD                             |
| 干                 | DIVISION OF Ital RECORDS, within 24 hours after death.  To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director: After this certificate has been stronglery filled in by the funeral director, page 2 should  | calc           | 29a Certifier  | y knowledge, death or<br>mination and/or invest | ccurred at the time<br>tigation, in my opir | e, date and p<br>nion, death o | lace, and due to the car<br>occurred at the time, dat | use(s) and manner as<br>e and place, and due | stated.<br>to the cause(s)                   |
|                   | Tot<br>Tot   | Medical        | and manner stated.  29b. Signature and title of certifier  |   |   | ense numbe                     |   |  | (Month, Day, Year)                           |
|                   |  |                | anetz  |   | 0.  | C.M.E.                         |   | August 9, 200                                | )7   |
| ħ                 | 7  |                | 30. Name and address of person who completed cause of a Ana Rubio MD. Assistant Medical Exam                             |   | n Street, Balt                              | imore, MI                      | 21201   |  |  |
| U                 |  | State          | 31. Date filed (Month, Day, Year) 32. Registra   | r's Signature                                   | house "                                     |                                |   |  |  |
|                   | Regi   |                |  | SHE DE  | Marie                                       |                                |   |  |  |
| DHM               | MH 17 Rev 1  | /2001          |  | ORIGI   | NAL   |                                |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 4b c per doc 870 8-15-07 vt. State of Maryland Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 08 **Physician** Year CONNICK Shannon 06 3:40 AN 2007 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins
5. Social Security Number Medical contur **Baltimore** Bayriew N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Yea 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Sex 1 □ M 2D F 216-86-8716 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or iteme 23a or 28a-f ehow treumatic event, the Mudical Examinar must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3028 21225 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Mever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 SNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) and Mental Hygiene. College (1-4or 5+) Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be Pages 1 and 2 should be CORNICK ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, If Item 27 I 20b. Place of Disposition (Name of cometery, crematory or other place) other Baltimore, 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ŏ 21. Signature of Funeral Service Licensee Name and Address of Facility Qu and 215.615 town 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** 5 grade 5 subav subavachnoid Nemorrhage /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and dbe detached for use as the burial-transit certificate be execu Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ۵ cete hes been sig., page 2 should b Completed 3 ☐ Probably 4 X Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificete hes autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes neral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one examiner' 1 ☐ Yes 2 No 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 Accident 5 Pending death. investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Direct 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7 08/06/2007 es 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Follmar 2HOC 8150 600 N. Wolfe St., Baltimore, MD 21787 MD 31. Date filed (Month, Day, Year)
AUG 1

DHMH 17 Rev 1/2001

State

Registrar

32. Signature

5 2007

|             |  |                  | for<br>State<br>Registrer  | State of M   | aryland                          |                            | artment of H  |                               | nd Menta                        |                                       | ene 007                                 | 26112   |
|-------------|--|------------------|--|--|----------------------------------|----------------------------|---|-------------------------------|---------------------------------|---------------------------------------|---|---|
|             | Dharisi  |                  | 1. Decedent's Name (First, Middle  | , Last)  |                                  |                            |   |                               |                                 | te of Death                           | Day Yea                                 | 3. Time of Death                                    |
|             | Physici<br>/Medic  |                  |  | atricia  | Ca1                              | .vo                        |   |                               | Au                              | gust                                  | 10, 2007                                | 7:10 A <sup>M</sup>                                 |
| ۶           | Examin   | er               | 4a. Facility Name (If not institution  | -  |                                  |                            | 4b. City, Town, or  |                               |                                 |                                       | 4c. County of De                        |   |
| -           |  |                  | Holy Cross Hea   |  | ge (In yrs. las                  |                            | If Under 1 Year   | onsvil                        |                                 | te of Rinth                           |   | omery   |
|             | Funeral<br>Director  |                  | 223-82-3653  | 1 M 2 F  | 54                               | Yrs.                       | Months Days   | Hours                         | Min. (Me                        | te of Birth<br>onth, Day, 1<br>t • 10 | Year) . 1952                            | irthplace (State or Foreign<br>Country)<br>Chile    |
|             | D D  |                  | Usual Residence of Decedent  |  |                                  |                            |   |                               | ВСР                             | 20                                    | , 1 ) 5 2                               |   |
|             | show   | 2                | Maryland Mont  | gomery   | 10c. City,                       | Town or Lo                 | Burton  | crillo                        |                                 |                                       |   | 10d. Inside City Limits 1 ☐ Yes 2 🖫 No              |
|             | the M  | ecto             | 10e. Street and Number   | gomet y  |                                  |                            | 10f. Zip Code   | 2 1 1 1 5                     | :                               | 100                                   | g. Citizen of What                      |   |
|             | 30 or  | io I             | 3415 Greencast   | le Rd.   |                                  |                            |   | 20866                         |                                 |                                       | United St                               | -   |
|             | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or Items 23e or 28e-f show<br>ha Medical Eserili or mat be notified at  | Funeral Director | 11. Marital Status   | 12. Was Deceden<br>Armed Forces                    |                                  | 13.                        | Was Decedent of H<br>f Yes, specify Cuba                        |                               | in? (Specify Y                  |                                       | 14. Race - Ar                           | nerican Indian,                                     |
| õ           | or Ite   | y Fu             | 1 Never Married 2 Marri  | ed 1 TYes 2 X                                      | No                               |                            | 1 □ Yes 2 🖾 No  | Specify:                      | ruerto ricari,                  | O(C.)                                 | Black, WI                               | White   |
| Š           | hours<br>tural',   | ed by            | 3 ☐ Widowed 4 X ivorced  | Il Yes, Give<br>Year or Dates                      |                                  |                            |   |                               |                                 | 14                                    |   |   |
| 'n          | in 72<br>"naal   | Completed        | 15. Decedent<br>(Specify only highes   | t grade completed)                                 |                                  | (Give                      | dent's Usual Occup<br>kind of work done o<br>DO NOT use retired | durina most                   | of working                      | 16                                    | 6b. Kind of Busines                     | ss/industry   |
| 21215-0036  | filed withi<br>Hygiene.<br>other than  | mo               | Elementary/Secondary (0-12)  | College (1-4or<br>2                                | 5+)                              | Tra                        | vel Agen  | t                             |                                 |                                       | Travel &                                | Leisure   |
| <u> </u>    | al Hygie<br>d other  | Bec              | 17. Father's Name (First, Middle,  |  | 1                                |                            |   |                               |                                 |                                       | aiden Sumame)                           |   |
| yla         | should be<br>and Mental<br>marked o  | L <sub>O</sub>   | Gabriel  |  | alvo                             |                            |   |                               | eleine                          |                                       |   | tchell  |
| Maryland    | iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.  If item 27 Is marked other than "natural", or Items 23e or 28a-1 show or other traumatic event, It is Modical Earther Inval Le notified at |                  | 19a. Informant's Name/Relationsh<br>Gabriel S. Cal                           |  |                                  |                            | ng Address (Street: Westbrook                                   |                               |                                 |                                       | -                                       | , <i>Zip Code)</i><br>VA 22030                      |
|             | ss 1 and 2<br>of Health ar<br>item 27 le<br>other trau   |                  | 20a. Method of Disposition   | · · · · · · · · · · · · · · · · · · ·              | 20b. Plac                        | e of Dispo                 | sition (Name of   | 1                             | Date                            | _                                     | Oc. Location - City                     |   |
| ballimore,  | permit. Pages 1 an<br>Deportment of Heal<br>Important: If item 2<br>any njury or other<br>once.  |                  | 1 Burial 2 Cremation 4 Donation 5 Other (Sp                                  | 3 □Removal from State                              | cen                              | netery, crei               | matory or other plac<br>ce Cremato                              | · 1                           | 8/11/07                         |                                       | Beltsvi                                 |   |
| Ī           | ortme<br>ortan   | H                | 21. Signature)of Funeral Service   |  | 00382                            |                            | 2. Name and Addres  |                               | 0/11/0/                         |                                       |   | Gist Ave.   |
| ă           | Dep<br>Impo  |                  | > Steph A Lot  | hun eine   | 00300                            | B                          | app Funer   | cal &                         | Cremat                          | ion Se                                |   | er Spring, MI                                       |
| ī           |  |                  | 23a. Part1. Enter the disease, or shock, or heart failure. List              | complications that cause<br>only one cause on each | ed the death.<br>line.           | Do not ent                 | er the mode of dyin   | g, such as c                  | ardiac or respi                 | ratory arres                          | st,                                     | Approxi   |
|             | Pnysician  |                  | Immediate Cause (Final disease or condition                                  | DUSP   | MAGIA                            | +                          |   |                               |                                 |                                       |   | Onset and Death  YEARS                              |
|             | /Medical<br>Examiner   |                  | resulting in death)  |  | s a conseque                     | ,                          | . 11-   |                               |                                 | _                                     |   | 140 . 2   |
|             | -12  | <u>.</u>         | Sequentially list conditions,  | U. same in the same in the same                    | A CERE                           |                            | AL HE   | Morra                         | LIMAG                           |                                       |   | JEAN  |
| ν           | ute:   | Examiner         | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events |  | (                                |                            |   |                               |                                 |                                       |   |   |
| ်<br>၁      | an an  |                  | resulting in death) Last   | Due to (or a                                       | s a conseque                     | nce of):                   |   |                               |                                 |                                       |   |   |
| 0000        | death certificate be executed attending physician and ad for use as the burial-transity.   | licai            |  | d  |                                  |                            |   |                               |                                 |                                       |   |   |
| Ď           | g p<br>as  | Physician/Med    | IF FEMALE:   | 23a If use outcom                                  | o of program                     |                            |   |                               |                                 | -                                     | 1                                       |   |
| Z<br>C<br>C | that the death cer<br>ed by the attendin<br>detached for use   | cian             | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No               | 23c. If yes, outcom  1 Live birth  4 Pregnant      | 2 Fetal de                       | eath 3[                    | Ectopic pregnancy Other (specify)                               |                               |                                 |                                       | 23d. Date of d<br>Month                 | Day Year  |
| 5           | y the  | ysic             | 1 ☐ Yes 2 No<br>9 ☐ Unknown  | 9□ Unknown   | It titlle or dea                 | J_                         | Other (specify)   |                               |                                 |                                       |   |   |
| ν,<br>L     | law requires that the<br>as been signed by th<br>2 should be detache   | by Pt            | Part II. Other significant condition   | ns contributing to death                           | but not resulti                  | ng in the u                | nderlying cause giv   | en in Part I.                 | 23                              | Be. Did toba                          | icco use contribute                     | to the cause of death?                              |
| Š           | w require<br>been slg<br>should b  |                  |  |  |                                  |                            |   |                               |                                 | 1 🗆 Yes                               | 200No_3                                 | Probably 4 ∐Unknown                                 |
| Hecord      | ie law requ<br>has been<br>je 2 shoul  | Completed        |  |  |                                  |                            |   |                               | 24                              | a. Was an<br>autopsy                  | 24b. Were                               | autopsy findings available o completion of cause of |
|             | Th<br>ate<br>pag   | Con              |  |  |                                  |                            |   |                               | 10                              | performe                              | ed? death<br>1 ☐ Y                      | ?   |
| V [Cal      | Attending Phyeicien: Thr death. ector: After this certificate by the funeral director, pag   | Be               | 25. Was case referred to medical examiner?                                   | Hospital:  |                                  |                            | Oth   |                               | of Death (Chec                  |                                       |   |   |
|             | Phys<br>r this<br>ral dir  | . To             | 1 Yes 2 No 27. Manner of Death   | 28a. Date of In                                    |                                  | VOutpatier  8b. Time of    | IL 3 DOA  | 4 KINUR                       |                                 |                                       | ce 6 Other (S)                          | pecify)   |
| 5           | th.<br>: Afte  | tion             | 1 Natural 5 Pending 2 Accident investig                                      | (Month, D  | ay Year)                         | Injury                     | Wor   | k?<br>Yes 2 ∐ N               |                                 |                                       |   |   |
| DIVISION OF | or Attending later death. Director: After in by the funer  | iffica           | 3 Suicide 6 Could r  | ned 286. Place of Ir                               | njury - At hom<br>atc. (Specify) | e, farm, str               | eet, factory, office  |                               |                                 | cation (Stre                          |   | Rural Route Number,                                 |
| 5           | tel or A<br>rs after<br>el Dire<br>ed in by  | Certification:   | - Inditional   | building, e  | nc. (opecity)                    |                            |   |                               |                                 | y Gr 7 G1777,                         |   |   |
|             | To the Hospitel or Attending Ph<br>within 24 hours after death.<br>To the Funerel Director: After th<br>completely filled in by the funeral  | edical           | (Check only 2 Medical I  | g Physician: To the bes<br>Examiner: On the basis  | of examination                   | edge, death<br>n and/or in | n occurred at the tin<br>vestigation, in my o                   | ne, date and<br>pinion, death | place, and du<br>occurred at th | e to the cau                          | use(s) and manner<br>e and place, and d | as stated.<br>ue to the cause(s)                    |
|             | To the within 2 To the complet   | Med              | 29b. Signature and title of certifier  | and manner s                                       | tated.                           |                            | 29c. Licens   | e number                      |                                 | 290                                   | d. Date signed, (Mo                     | nth. Dav. Year)                                     |
|             | 5 1 K 1  |                  | Viole 2/   | Oh   |                                  |                            |   |                               | ho                              | 250                                   | 8/10/2                                  | 007   |
|             | 0  |                  | 30. Name and address of person   | who completed cause of                             | death (Item 2                    | 3a) (Type.                 | Print)  | -7 (                          | , –                             |                                       | 0 11-1                                  | 1   |
|             | 7  |                  |  | uscle m  | 2 7                              | 500                        | Green.  | way                           | CHF                             | Dr. (                                 | weenbe                                  | 007   |
|             |  |                  | Dr. D. L. W. A. A. L. ask Dev. Minest  | 22 <b>4</b> 7 7 1 2                                | rare Signatur                    | 0                          | 4   | -1                            |                                 |                                       |   |   |

2007 26!!3

| NK UNK  | 1.             | State of Maryland / Department of Hea   |  | rgierie<br>Reg.                  | 4 U                                 | 0/ 2011   |
|---|----------------|---|--|----------------------------------|-------------------------------------|---|
| Physician   | / 1            | egistrar<br>Decedent's Name (First, Middle,Last)  |  | Date of Death     Month     D    | av Year                             | 3. Time of Death                                    |
| ledical Examine   |                |   | Town, or Location of Death                                   | August 9, 20                     | 4c. County of Death                 |   |
|   |                | TOOD HOLD GUIDOL  | more der 1 Year   If Under 24Hrs.                            | 8. Date of Birth (               | MM/DD/YYYY) 9. Bit                  | thplace (State or                                   |
| Funeral<br>Director   | 4              | 578.96.4501 1XM 2 F 36 Yrs. Mon   |  | -                                | Forei                               | ountry) DC  |
| ' any.  |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location   |  | ,                                |                                     | 10d. Inside City Limits  1 Yes 2 No                 |
| Aaryland 28a-f show 1 at once.  | <u> </u>       | MD Baltmore ESSex  10e. Street and Number 10f. 2  | ip Code  | 10g                              | . Citizen of What Cou               |   |
| the N a or tiffee   |                | 804 Briar Hill Place  | 21221  |                                  | USA                                 | rican Indian, Black,                                |
| r death with  | unera          | 11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No   | dent of Hispanic Origin? ( Sp<br>cify Cuban, Mexican, Puerto | Rican, etc.)                     | White, etc.                         | ncan Indian, Black,                                 |
| hours after d   | a -            | 3 Widowed 4 Divorced of Potes:  | 2 X No specify: al Occupation (Give kind of w                | vork done                        | Specify: 6b. Kind of Business       | /Industry   |
|   | ompleted       | Elementary/Secondary (0-12) College (1-4 or 5+)   | orking life. DO NOT use retir                                | red)                             | Home ]                              | mprovement  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica  | E -            | 17. Father Name (First, Middle, Last)   | 18.Mother's Name   |                                  | iden Surname)                       |   |
| 21215-00 uld be filed wit Mental Hygien marked other c event, the M   | 8<br>L         | EVNPST Contee SV.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Addre   | ss (Street and Number or F                                   |                                  |                                     | e, Zip Code)  |
|   | - [            | Christel L. Contee Wife 804 Bi  | 1ar Hill Pl  | ace Ess                          | Sex MD  20c. Location - City of     | 21221   |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical  |                | 20a. Method of Disposition  20b. Place of Disposition (Notice and Property of State)  20c. Place of Disposition (Notice and Property of State)          | ce)  | Date   17   07                   | Baltimoi                            |   |
| Baltim<br>permit. Pa<br>Departmen<br>Important<br>injury or or  | 1              | 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name a  | nd Address of Facility Qu                                    | ighn C. G                        | reene Fune                          | ral nices   |
| Physician   | 1              | 23a. Part I. Birler the disease, or complications that caused the death. Do not enter the modern the modern than the modern that caused the death.      | York Road To   | Saltinor<br>or respiratory arres | e M) 212<br>st, shock, or heart     | Approximate Interval Between Onset and              |
| Medical   |                | failure. List only one cause on each line.  Immediate Cause (Final disease a. Narcotic intoxication (Morph:   | ine) and cocaine   | use                              |                                     | Death   |
|   |                | or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.   |  |                                  |                                     |   |
|   | Examiner       | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c                         |  |                                  |                                     |   |
| outed and ransit  |                | events resulting in death) Last  Due to (or as a consequence of):  d.   |  |                                  |                                     |   |
| 60, ate be executed hysician and te burial - transit  | edica          | X amended X amended #8, perFH, 6870, 8/15/07 TT   | // #23a,27,28a-1   | f, perME,g8                      | 870, 8/23/07                        | TT  |
| ox 68760, eath certificate be ex attending physician for use as the burial  |                | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea                                |  | ancy                             | Month                               | Day Year  |
| Box 687 e death certifica the attending p ed for use as th  | hysic          | 1 Yes 2 No 9 Unknown 9 Unknown  |  | OSS Did tol                      | and the contribute                  | to the cause of death?                              |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi |                | Part II. Other significant conditions contributing to death but not resulting in the underly  | ring cause given in Part I.                                  |                                  |                                     | robably 4 🗹 Unknown                                 |
| of Vital Records, P.O. ng Physician: The law requires that it there this certificate has been signed by meral director, page 2 should be detec-   | Completed by   |   |  | 24a. Was a autops                | y prior to                          | autopsy findings available o completion of cause of |
| tal Reccitan: The la  | SOU            |   | 26.Place of Death (Check                                     | 1 <b>✓</b> Yes 2                 |                                     |   |
| Vital   nysician: this certif   | o Be           | 25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3   | Tothes   | ng Home 5                        | Residence 6 🗸 Ott                   | ner: Scene  |
| n of Ading Ph.  | uo.            | 27. Manner of Death  1 Natural 5 Pending Fnd 8/9/2007 Fnd 11:50 a   | 28c. Injury at Work?   | 28d. Describe h                  | ow injury occurred                  |   |
| Division rs after death. al Director: A led in by the fu  | Certification: | 2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, fac   |  | 28f. Location (S                 | treet and Number or<br>astle St. Ba | Rural Route Number, City                            |
| Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the   |                | 4 Homicide determined (Specify) Found in warehouse  29a. Certifier (Check park)  1 Certifying Physician: To the best of my knowledge, death occurred at | the time, date and place, an                                 | d due to the cause               | e(s) and manner as s                | tated.  |
| To the within 2 within 2 To the I complete  | Medical        | one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.  | my opinion, death occurred                                   | at the time, date a              | and place, and due to               | the cause(s)  |
| 2   | 2              | 29b. Signature and title of certifier   | O.C.M.E.   |                                  | August 10, 200                      | _   |
|   |                | 30. Name and address of person who completed cause of death (Item 23a)  Maliana Proposal MD Assistant Medical Examinar 111 Penn                         | Street, Baltimore, MD  | 21201                            |                                     |   |
| Sta   | ite            | 31. Date filed (Month, Day, Year) 32. Registrar's Signature   |  |                                  |                                     |   |
| Registr   | or             | AUG 1 5 2007 Money D. Space   |  |                                  |                                     |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CARTER DVAID 14:23 M 2007 August 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL NA BALTIMORE CIT Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 09 21 Birthplace (State or Foreign Country) **Funeral** 218.92.3557 1**X**M 2□ F Months Days Hours Min Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits MD Baltimore **Funeral Director** 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Avenue 1009 Darley 21218 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒No Specify: Specify: Black Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Towson State College (1-4or 5+) Elementary/Secondary (0-12) Cashier 11 th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Irving Manu ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number of Rural Route Number City or Town, State, Zip Code) Carter Avenue Baltimore Mother Darley 20a. Methed of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Pages Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) Mt. Zion Cemetery Baltmore, MD 08/18/07 21. Signature of Funeral Service Lieensee 22. Name and Address of Facility Vaughn C. Orlene Funeral Srvcs 4905 York Road Baltimore MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) PNEUMOCHSTIS JEROVECII PNEUMONIA 6 days /Medical Due to (or as a consequence of) Examiner 8 years HUMAN IMMUNODEFICIENCY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an autopsy 1□ Yes 2EXNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 KInpatient Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director; filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) AUGUST, 11, 2007 MEDICAL DOCTOR RES- 000

State Registrar 31. Date filed (Month, Day

DHMH 17 Rev 1/2001

TUAN M. TRAN, JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BUTTMUKE, MARYLAND 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

5 2007

. Registrar's Signature

|   |  |                  | For<br>State<br>Registrar   | State                                    | e of Ma                         | arylan      | d / Depa                                 | artment<br>r <i>tificate</i> |                                 |                                | Ment                 | , ,                       | -                   | 00 ===                      | 0.5   | 6 1 pm       |
|---|--|------------------|---|--|---------------------------------|-------------|--|------------------------------|---------------------------------|--------------------------------|----------------------|---------------------------|---------------------|-----------------------------|---|--------------|
|   | -  |                  | Registrar  1. Decedent's Name (First, Mi  | iddle. Last)                             |                                 |             | Cei                                      | uncate                       | or De                           | eatn                           | 2. D:                | ate of Dea                | Reg. No. /          | UII/                        | 3. Time of                                  | Death        |
| ·F  | Physici<br>/Medic  |                  | ROBERT  | LEWIS                                    | CRA                             | WFOR        | D  |                              |                                 |                                |                      | onth<br>GUST              |                     | 2007                        | 11:05                                       |              |
|   | Examir   |                  | 4a. Facility Name (If not institu   | -  | ,                               |             |  | 4b. City, To                 | wn, or Loc                      | cation of Dea                  | ith                  |                           |                     | ounty of Death              |   |              |
|   |  | 燕                |   | CK MEMORI                                |                                 |             |  | FREDE                        |                                 | Ilmda a Od III-                |                      |                           |                     | DERICK                      |   |              |
|   | uneral<br>rector   |                  | 5. Social Security Number 220–54–4584   | 6. Sex<br>1 ☑ M 2 ☐                      |                                 |             | ast birthday)<br>56 Yrs.                 | If Under 1<br>Months         |                                 | Under 24 Hrs<br>lours Min      | (N                   | te of Birth<br>fonth, Day | $\frac{1}{195}$     | Cou                         | place <i>(Stat</i> e or<br>intry)<br>ryland | r Foreign    |
| ъ   | A.   |                  | Usual Residence of Decedent   |  |                                 |             |  |                              |                                 |                                | oct                  | . 13                      | , 195               | oi na                       | Гутани                                      |              |
| arylar  | show<br>d at   | 'n               | 10a. State 10b. Cou   |  |                                 | 10c. City   | , Town or Lo                             |                              |                                 |                                |                      |                           |                     |                             | 10d. Inside Cit                             |              |
| the M   | 28a-f<br>lotifie   | ecto             | Maryland F1   | rederick                                 |                                 |             | Frede                                    |                              |                                 | -                              |                      |                           | 10- 02              |                             | 1 XYes                                      |              |
| with  | 3a or<br>at be r   | Ē                | 21 Degrange S   | treet                                    |                                 |             |  | 10f. Zip C                   | 701                             |                                |                      |                           |                     | n of What Cou<br>.ted Sta   | ·   |              |
| death   | r mus  | Funeral Director | 11. Marital Status  | 12. Was                                  | Decedent                        | Ever in U.  | S. 13.                                   |                              |                                 | ınic Origin? (<br>Mexican, Pue | Specify Y            | es or No-                 |                     | . Race - Ameri              | can Indian,                                 |              |
| d 21215-0036<br>flied within 72 hours after death with the Maryland<br>Hygiene.   | Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Fu            | 1 ☐ Never Married 2 ☐ M<br>3 ☐ Widowed 4XX Divord   | Married 1 TY                             | /es 2⊠1<br>s, Give<br>or Dates: | No          |  | 1 ☐ Yes 2                    |                                 | pecify:                        | no rican             | etc.)                     |                     | Black, White<br>pecify: Whi |   |              |
| <b>5-0</b>  | natur<br>dical I   | Completed by     | 15. Deced   | dent's Education sphest grade comple     | ted)                            |             | 16a. Dece                                | dent's Usual                 | Occupation                      | n<br>na most of wa             | orkina               |                           | 16b. Kind           | of Business/Ir              | ndustry                                     |              |
| vithin ne.  | han "<br>e Me  | mpl              | Elementary/Secondary (0-12  |  | ge (1-4or 5                     | i+)         |  |                              | retired)                        | ng most of wo                  | , ming               | - 1                       | _                   |                             |   |              |
| filed v   | other i  |                  | 17. Father's Name (First, Midd  | dle, Last)                               | 2                               |             | Mana                                     | ger                          | 18.                             | . Mother's Na                  | me (Firs             | . Middle.                 | Ret<br>Maiden Su    |                             |   |              |
| lan<br>lid be<br>fental   | rked o   | To Be            | Leslie Crawfo   |  |                                 |             |  |                              |                                 | arion                          | •                    |                           |                     |                             |   |              |
| and N   | is mai   | _                | 19a. Informant's Name/Relation  | , ,                                      |                                 |             | 1  |                              |                                 |                                |                      |                           |                     | own, State, Zi              | v Code)                                     |              |
| and and lealth  | m 27<br>her tra  |                  | Justin S. Cra   | wford / S                                | Son                             | 1001 5      |  |                              |                                 | , Fred                         |                      |                           |                     |                             |   |              |
| Baltimore, Maryland 21215-0036<br>permit. Pages 1 and 2 should be filed within 72 hours aft<br>Department of Health and Mental Hygiene. | nt: If ite<br>iry or ot  |                  | 20a. Method of Disposition  1 ☐ Burial 2 ☑ Crematic  4 ☐ Donation 5 ☐ Other                                 |  | rom State                       | CE          | lace of Dispo<br>emetery, crer<br>thaver | natory or oth                | er place)                       | Augu                           | Date<br>ist 1<br>200 | 1,                        |                     | tion - City or T            |   | , d          |
| alti<br>ermit.<br>epartin   | porta<br>ny Inju   |                  | 21. Signature of Fundal Selv  | ice Lice Isee                            |                                 |             | 22                                       | Name and                     | Address of                      | f Facility                     | _                    |                           |                     | ot Cod                      |   | iu           |
|   | 트등리  |                  | 1//   | 9/                                       |                                 |             | 95                                       | 01 Cat                       | octi                            | n Mtn.                         | $H_{WV}$             | . Fr                      | ederi               | ck, MD                      | 21701                                       |              |
| 15 15   |  |                  | 23a. Para. Enter the disease shock, or heart failure. I   | , or plications th<br>List nly one cause |                                 |             |  |                              |                                 |                                | ac or resp           | iratory arr               | est,                |                             | Approximate<br>Interval Betw<br>Onset and D | veen         |
|   | sician<br>edical   |                  | disease or condition resulting in death)  | a  | <i>A(U1</i><br>e to (or as      | ER          | ENAL                                     | FAS                          | ZUR                             | E                              |                      |                           |                     |                             |   |              |
| Exa   | miner  |                  | 0   |  |                                 |             | LIC                                      | ACIL                         | DOSI                            | 5                              |                      |                           |                     |                             |   |              |
| , D   | #  | iner             | Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury | Due Due                                  | e to (or as                     | a consequ   | ence oi).                                |                              |                                 |                                |                      |                           |                     |                             |   |              |
| <b>68760,</b> <   | physician and<br>s the burial-transit  | Examiner         | that initiated events resulting in death) Last  | c  | RES.                            |             | TORY                                     | FAIL                         | URE                             | -                              |                      |                           |                     |                             |   |              |
| <b>58760,</b> ficate be exe   | sician<br>e buria  |                  |   |  | 3 to (01 do                     | a concequ   | 01100 017.                               |                              |                                 |                                |                      |                           |                     |                             |   |              |
| ₩ :==   | ig phy<br>as the   | edical           |   | 0.                                       |                                 |             |  |                              |                                 |                                |                      |                           |                     |                             |   |              |
| Records, P.O. Box The law requires that the death cert  | attending<br>for use as  | Physician/M      | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?  | 23c. If yes<br>1 □ L                     | , outcome<br>ive birth          |             |  | lEctopic preg                | nancv                           |                                |                      |                           | 230                 | d. Date of deliv            |   |              |
| De des  | the at<br>hed fo   | /sici            | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   |  | regnant at<br>Inknown           | time of de  |  | Other (spec                  |                                 |                                |                      |                           |                     | Month                       | Day Y                                       | 'ear         |
| , P.O.  | signed by the signed be detached in  |                  | Part II. Other significant cond   | ditions contributing                     | to death bu                     | ut not resu | Iting in the ur                          | derlying cau                 | se given in                     | Part I.                        | 2                    | 3e. Did to                | bacco use           | contribute to t             | he cause of de                              | eath?        |
| Vital Records, sician: The law requires the   | been sign<br>should be   | od by            | HIV   |  |                                 |             |  |                              |                                 |                                |                      | 1 🗆 Y                     | es 2 🗆 I            | No 3∏ Pro                   | bably 4 📈 Ú                                 | ,<br>Inknown |
| aw re   | 2 sho  | plete            | THRUM BO  | CYTOPEN                                  | JIA                             |             |  |                              |                                 |                                | 2                    | ta. Was a                 |                     | 24b. Were auto              | opsy findings a                             | ıvailable    |
|   | rector, page 2 s   | Completed        | LYMPHO  | MA                                       |                                 |             |  | _                            |                                 |                                | 1[                   | autops<br>perform<br>Yes  | med2<br>2 No        | death?                      | mpletion of ca<br>2□ No                     | use of       |
| VITE  | ector,   | Be               | 25. Was case referred to med examiner?  | Hoenital                                 |                                 |             |  |                              |                                 | Place of De                    | ath (Che             | ck only or                | re)                 |                             |   |              |
|   | er this  | 2                | 1 ☐ Yes 2 ☑ No  27. Manner of Death   | 28a. D                                   | 1. Inpatie Date of Inju         | ry T        | ER/Outpatien<br>28b. Time of             |                              |                                 | 4 ☐ Nursing                    |                      |                           | ence 6 Downinjury o | Other (Speci                | fy)   |              |
| on aging  | r: Affe<br>e fune  | ation            | 1 ☑ Natural 5 ☐ Pen<br>2 ☐ Accident inve  | iding (/<br>estigation                   | Month, Day                      | Year)       | Injury                                   | М                            | . Injury at<br>Work?<br>1 ☐ Yes | 2 □No                          |                      |                           | ,,                  |                             |   |              |
| DIVISION OF<br>Il or Attending Phys<br>after death.   | Directo<br>I in by th  | Certification:   |   |  | lace of injubilities            |             | me, farm, stre                           | eet, factory, o              | ffice                           |                                |                      | cation (Si                |                     | Number or Run               | al Route Numb                               | ber,         |
| pital<br>ours a   | filled   |                  | 29a. Certifier 1 Certif   | fying Physician: To                      | the hest o                      | of my know  | vledge death                             | occurred at                  | the time                        | tate and plac                  | e and du             | e to the o                | aneo(e) ar          | nd mannor as                | hotete                                      |              |
| To the Hospital or within 24 hours after  | oletely  | Medica           | (Check only one)  | cal Examiner: On the                     | he basis of<br>manner sta       | examinati   | ion and/or in                            | estigation, ir               | my opinio                       | on, death occ                  | curred at t          | he time, o                | late and pl         | ace, and due t              | o the cause(s)                              | j            |
| To th   | d<br>moo   | Ĭ                | 29b. Signature and title of cen   | ifier                                    |                                 |             |  |                              | icense nu                       |                                |                      | 2                         | -                   | signed (Month,              | -   |              |
|   |  |                  | > Alreh   | MD                                       |                                 |             |  | I                            | 006                             | 3498                           | 7                    |                           | 8                   | -10-0                       | 7   |              |
| 10  | )  |                  | 30. Name and address of pers  |  | cause of de                     | . ^         | 23a) (Type, I<br>M D                     | ,                            | 7.1                             | C                              |                      | 1                         |                     | MD 011                      | 701   |              |
| 1   | Sta  | e                | 31. Date filed (Month, Day, Ye.   |  | 2. Registra                     |             | ure                                      |                              |                                 | stree                          | t, F                 | rede                      | rıck,               | MD 21                       | /01   |              |
| 0,  | Registra   |                  | ALIC  | 1 5 2007                                 | 90                              |             | H.                                       | Angel.                       | 9                               |                                |                      |                           |                     |                             |   |              |

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|   |                | For State Registrar  | tate of Mar   | yland /                | •                        | rtment of H<br>tificate of I                                  |                               | ,                                       | giene<br>Reg. No.                      | 117                        | 26117  |
|---|----------------|--|---|------------------------|--------------------------|---|-------------------------------|---|--|----------------------------|--|
| Physicia  | an             | Decedent's Name (First, Middle, Last)  |   |                        |                          |   |                               | 2. Date of De                           | eath                                   | Vear                       | 3. Time of Death                                   |
| /Medic  | al             | Concepcion Ch.  4a. Facility Name (If not institution, give street   |   | Vda. 1                 | DeRam                    |   |                               | August                                  |  | 007                        | 12:25P M   |
| Examin  | er             | 6121 Wayside Dr.   | t and number)   |                        |                          | 4b. City, Town, or Roc  | kville                        | h                                       | 4c. County of                          | of Death<br>1 <b>tgo</b> m | erv  |
| Funeral   |                | Social Security Number 6. Sex  |   | In yrs. last           |                          | If Under 1 Year<br>Months Days                                | If Under 24 Hrs<br>Hours Min. | 8. Date of Bir                          | th                                     |                            | lace (State or Foreign                             |
| Director  |                | 214-55-2606 1□ M Usual Residence of Decedent   | 24  | 93                     | Yrs.                     |   | Tiodis Willi.                 | Dec. 13                                 | 3, Year)<br>3, 1913                    |                            | ivia   |
| yland<br>now<br>at  |                | 10a. State 10b. County   | 1   | 0c. City, To           | own or Loc               |   |                               |   |  | 10                         | Od. Inside City Limits                             |
| ne Mar<br>8a-f sl   | Director       | Maryland Montgome:   | СУ  |                        |                          | Rock  | ville                         |   |  |                            | 1 □ Yes ŽŽNo                                       |
| with the Maryland<br>a or 28a-f show<br>be notified at  | Dire           | 10e. Street and Number 6121 Wayside Dr.  |   |                        |                          | 10f. Zip Code   | 0852                          |   | 10g. Citizen of W<br>Bolivi            |                            | try?   |
| er death w<br>items 23a<br>ner must l   | Funeral        | 11. Marital Status 12. V   | Vas Decedent Eve  | er in U.S.             | 13. V                    | /as Decedent of Hi<br>Yes, specify Cuba                       |                               | specify Yes or No                       |  | - America                  |  |
|   | by             | 1 □ Never Married 2 □ Married  | Armed Forces?  Yes 2 No Yes, Give ear or Dates:                       |                        |                          | Yes, specify Cuba<br><b>X</b> Yes 2□ No                       |                               | to Rićan, etc.)<br>olivian              | Black<br>Specify:                      | , White, 6<br>Wh           | ite  |
| 15-C  | letec          | 15. Decedent's Education (Specify only highest grade control of the control of th | n<br>mpleted)   | 16                     | 6a. Deced<br>(Give I     | ent's Usual Occupa<br>ind of work done o<br>O NOT use retired | ation<br>Juring most of wo    | rking                                   | 16b. Kind of Bus                       | iness/Ind                  | lustry   |
| withir iene.  | Completed      | Elementary/Secondary (0-12) 5  | College (1-4or 5+)  |                        |                          | onor use retired,<br>omemaker                                 | )                             |   | Own                                    | Hom                        | e  |
| rland 2<br>uld be filed<br>Aental Hygi<br>rked other<br>tic event, ti                           | To Be C        | 17. Father's Name (First, Middle, Last) Pedro  | Choque  |                        |                          |   | 18. Mother's Nar<br>Beni      |   | Maiden Surname<br>De Ch                |                            |  |
| and and sum sum   |                | 19a. Informant's Name/Relationship (Type. I<br>Tula B. Ramos / Daug  |   | 1:                     |                          | Address (Street a   |                               |   |  | State, Zip<br>1852         | Code)  |
| iges 1 and 2 art of Health if item 27 i or other tra  |                | 20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ Remo   |   | ceme                   | tery, crem               | ition (Name of<br>atory or other place                        |                               | Date                                    | 20c. Location - 0                      | ,                          | ,  |
| Baltimol permit. Pages Department of Important: If is any Injury or once.                       |                | 4 □ Donation 5 □ Other (Specify)  21. Signature on Funeral Service Licenses  |   |                        | _                        | e Cremato Name and Addres                                     |                               | 4/07                                    | Beltsv                                 |                            | , MD<br>st Ave.209                                 |
| Balt<br>permit.<br>Departi<br>Importi<br>any Inj<br>once.                                       | d 9            | > Stole Anoly  | mann  | 10382                  | Ra                       | pp Funera   | al & Cre                      | mation S                                | ers. Sil                               | ver                        | Spring, MD   |
| Physician<br>/Medical<br>Examiner   | _              | 23a. Part1. Enter the disease, of complications shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  | Due to (or a  | Fall                   | ure.<br>e of):           | r the mode of dying   | g, such as cardiad            | c or respiratory a                      | rrest,                                 | _1                         | Approximate<br>Interval Between<br>Onset and Death |
| uted<br>d<br>ansit  | Examiner       | if any, leading to immediate bause. Either Unidenying Cause (Disease or injury that initiated events   | Due to (or as a c   | onsequenc              | e of):                   |   |                               |   |  |                            |  |
| 68760,<br>lificate be executed<br>g physician and<br>as the burial-transit                      | edical Exa     | resulting in death) Last   | Due to (or as a c   | onsequenc              | e of):                   |   |                               |   |  |                            |  |
| death certi   | Physician/Mec  | in the past 12 months?   | yes, outcome pf p<br>□Live birth 2 [<br>□Pregnant at tirn<br>□Unknown | Fetal dea              |                          | Ectopic pregnancy<br>Other (specify)                          |                               |   | 23d. Date<br>Mon                       |                            | y<br>Day Year                                      |
|   | ۾              | Part II. Other significant conditions contributions of the significant conditions of the sig |   |                        | in the und               |   | n in Part I.                  | 23e. Did to                             | obacco use contrib<br>⁄es 2□ No 3      | oute to the                | 4  |
| Rec   | Completed      |  |   | •                      |                          |   |                               | 24a. Was<br>autop<br>perfo<br>1 Yes     | pr<br>rmed? de                         | ior to comeath?            | sy findings available pletion of cause of          |
| on or Vital Reding Physician: The Affer this certificate he funeral director, page              | Be             | 25. Was case referred to medical examiner?   | tal:  |                        |                          | Otho  |                               | th (Check only o                        |  |                            |  |
| OF<br>Phys<br>er this<br>eral dil   | 2              | 1 163 2 110  | a. Date of Injury   | 2   ER/C               | Outpatient<br>. Time of  | 3 DOA Other   | 4 ☐ Nursing H                 |   | lence 6 Dother                         |                            | )  |
| vision or Vita Attending Physician: death. ector: After this certific. by the funeral director, | atior          | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day Ye  | ear)                   | Injury                   |   | ?<br>es 2 □ No                |   |  |                            |  |
| Divisor Atter as after de al Directo ed in by the   | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined   | e. Place of injury<br>building, etc. (8                               | - At home,<br>Specify) | farm, stree              | et, factory, office   |                               | 28f. Location (5<br>City or Tou         | Street and Number<br>vn, State)        | or Rural                   | Route Number,                                      |
|   | Medical (      | 29a. Certifier (Check only one) Certifying Physicial 2 Medical Examiner:   | n: To the best of m<br>On the basis of ex<br>and manner stated        | amination a            | ge, death<br>and/or inve | estigation, in my op  | inion, death occu             | e, and due to the<br>arred at the time, | cause(s) and man<br>date and place, ar | ner as sta                 | ated.<br>the cause(s)                              |
| To T Com  | Σ              | 29b. Signature and title of certifier  | y Deel  | Su                     | ٥٠                       | 29c. License  |                               |   | 29d. Date signed                       |                            |  |
| H   |                | 30. Name and address of person whicomple Barry Hecht, M. 31. Date filed (Month, Day, Year)   | ted cause of death  | 3941                   | (Type, P                 | Tara T  | or. Whe                       | enton, m                                | 10 2090                                | 6                          |  |
| Stat<br>Registra  |                | AUG 1 5 2007   | 32 Registrar's  | Signature              | loo                      | ALD.  |                               |   |  |                            |  |

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Harold Lloyd Dye, Sr. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bo-1+i more Franklin Square Oseda HOSO: ta 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 X M 2 □ F Director 82 208-16-3688 Pennsylvania July 9, 1925 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4209 Haycoke Road 21236 U. S. A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 N Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Social Security filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Administration Claims Examiner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If Item 27 Is marked of any Injury or other traumatic even once. Pages 1 and 2 should be Merle Dye Nancy Moore 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Dye, Jr. (Son) 8 Mallow Ct., Perry Hall, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 08/14/2007 Baltimore, Maryland 21. Signatu (of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. 9705 Belair Road, Baltimore, Maryland 21236 23a. Part1. Enter the diseas shock, or heart failure. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a. Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in list and asserts. Due to (or as a consequence of Examine The law requires that the death certificate be executed nding physician and use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Dementio autopsy perform 1∐ Yes 25. Was case referred to medical examiner? Be ( 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Certification: To this 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After 1 Natural 2 Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

(Check only one)

29b. Signature and title of certifier

2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, MD 2/337 Dr wassin 31. Date filed (Month, Day, Year) AUG 1 32. Registrar's Signature

29d. Date signed (Month, Day, Year)

State Registrar

h

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** forma PUCKET 2007 11:00 191 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cranesis Havework Bouchmore City baltraine If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 59 Director 248-80-3516 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at Director 1 X Yes 2 No MD NA Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or Items 23a 6617 Marott Drive Funeral 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. once. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2yrs Nurse Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Harris Jesse Taylor 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Travertine Ct Townsend, DE 19734 Robin Davis-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crescent Hill Memorial Gardens 8/16/2007 Columbia, SC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West Cole 4300 Wabash Ave, Baltimore, Md 21215 23a. Tart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hiv 60-5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Physician/Medical Examine that initiated events resulting in death) Last attending physician and for use as the burial-tra Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2/No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/13/57 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Wendy Kluesz 31. Date filed (Month, Day, Year) AUG 1 5 2007

6701 H Charles St Svite 4202 32. Redistrar's Signature

|          |   |                | For State Registrar   | State                                    | of Marylar                                      |                      | epartment of H<br>Certificate of L   |  |  | ene 2 0             | 07            | 26120                                     |
|----------|---|----------------|---|--|---|----------------------|--|--|--|---------------------|---------------|---|
| -        | Physici   | an             | 1. Decedent's Name (First, Mid  | ldle, Last)                              |   |                      |  |  | 2. Date of Death<br>Month              |                     | Year          | 3. Time of Death                          |
| 100      | /Medic  |                |   |  | Doroth  | y Di                 |  |  |  | ug 1 <u>2, 20</u> ( |               | 6:03 a                                    |
|          | Examin  | er             | 4a. Facility Name (If not instituti   | -  | ·   |                      |  | Location of Death                            |  | 4c. County of       | of Death      |   |
|          | Funeral   |                | 5. Social Security Number   | wood Extended                            | Care Nurs                                       | ing H                | ome<br>hday) If Under 1 Year   | Reiste                                       | erstown<br>8. Date of Birth            |                     |               | ace (State or Foreign                     |
|          | Director  |                | 212-22-3835   | 1 □ M 2 □ F                              |   |                      | rs. Months Days  | Hours Min.                                   | (Month, Day, \                         | 'ear)               | Coun          | try)                                      |
|          | pui ,   |                | Usual Residence of Decedent   |  |   |                      | or Location  |  | Jan 1,                                 | 1923                |               | o. Carolina                               |
|          | faryia<br>shoved at   | ŏ              |   | ,  | 100.01  | ty, rown             | or Location  |  |  |                     | 10            | od. Inside City Limits 1 □ Yes 2 □ No     |
|          | the A<br>28a-1  | Director       | Maryland  10e. Street and Number  | N/A                                      |   |                      | 10f. Zip Code  | Baltimore                                    | 100                                    | . Citizen of Wi     | hat Cause     | ^   |
|          | 3a or   | i Di           | 751 West Saratog  | a Street                                 |   |                      | Toi. Zip Code  | 04045  | 100                                    | g. Oilizeii oi vvi  |               |   |
|          | deatl   | Funeral        | 11. Maritai Status  |  | cedent Ever in U                                | .S.                  | 13. Was Decedent of Hi   | 21215<br>spanic Origin? (Spe                 | cify Yes or No-                        | 14. Race            |               | an Indian,                                |
| ð        | 72 hours after death with the Maryland<br>natural", or Items 23a or 28a-f show<br>dical Examiner must be notified at  | y Fu           | 1 Never Married 2 Ma  | arried 1 ☐ Yes                           | 2 □ No<br>ive X                                 |                      | If Yes, specify Cuba<br>1 ☐ Yes 2 ☐ No   | Specify:                                     | nican, etc.)                           |                     | , White, e    | etc.                                      |
| 5-0036   | hours<br>tural";  | d by           | 3 ☐ Widowed 4 ☐ Divorce   | ed Year or I                             | Dates:  | 140                  | 1 ☐ Yes 2 ☐ No<br>X  |  |  | Specify:            |               | Black                                     |
| ဂ်       | in 72<br>"na" r   | Completed      | (Specify only high  | ent's Education<br>nest grade completed, |   | 16a.                 | Decedent's Usual Occupa<br>(Give kind of work done of<br>life. DO NOT use retired) | ation<br>luring most of workir<br>)          | ng 16                                  | b. Kind of Bus      | iness/Ind     | ustry                                     |
| 717      | yene.<br>r than "<br>the Mec  | E O            | Elementary/Secondary (0-12)   | College                                  | (1-4or 5+)                                      |                      |  | nemaker                                      |  |                     | Own H         | iome                                      |
| p        | be filed within 72 hours after death with the Marylar ital Hygiene. dother than "natural", or ftems 23a or 28a-f show event, the Medical Examiner must be notified at           | BeC            | 17. Father's Name (First, Middle  | e, Last)                                 |   |                      |  | 18. Mother's Name                            | (First, Middle, Ma                     | iden Surname        | )             |   |
| N T      | 2 should be and Menta is marked raumatic ev   | <b>To</b>      | A   | Malcolm Smith                            |   |                      |  |  | Annie Eli                              | zabeth Br           | raboy         |   |
| Jan      | ges 1 and 2 should<br>it of Health and Men<br>If item 27 is marke<br>or other traumatic   |                | 19a. Informant's Name/Relation  | nship (Type. Print)                      |   | 19b.                 | Mailing Address (Street a  | nd Number or Rura                            | l Route Number, (                      | City or Town, S     | state, Zip    | Code)                                     |
| e<br>G   | 1 and 2<br>Health<br>tern 27 i  |                | Michael Dillard So  | n  | Tools 1   | Dinne of I           | 3924 Algiers R   |  |  |                     |               |   |
| _        | Pages nent of H   |                | 20a. Method of Disposition 1 ☐ purial 2 ☐ Cremation                             |  |   | cemetery             | Disposition (Name of<br>r, crematory or other place                                | ∌) ¦ D                                       | ate 20                                 | c. Location - C     | City or Tov   | vn, State                                 |
| OE III   | + 두 본 분   |                | 4 □ Donation 5 □ Other (  |  | - /   | Maryla               | and National Park<br>22. Name and Addres   | Cemetery                                     | 08/18/07                               | Lau                 | irel, Ma      | aryland                                   |
| ם<br>מ   | Depar<br>Impo<br>any ir   |                | X long  | 71 8                                     | 500   | 0                    |  | rothers Funer                                | ol Conico D                            |                     |               |   |
| F        |   |                | 23a. Part1. Enter the disease, or head follows.                                 | or complications that                    | caused the ded                                  | h. Do no             | ot enter the mode of dying   | Haw Place Ba                                 | respiratory arrest                     | <del>21217 -</del>  |               | Approximate                               |
|          | Physician   | 7 7            | shock, or heart failure. List<br>Immediate Cause (Final<br>disease or condition | st only one cause on                     | GAA   | Ch                   | u Deme   | entri  |  |                     | 1             | Interval Between<br>Onset and Death       |
|          | /Medical  | Ш              | resulting in death)   | a. Due to                                | (or as a conseq                                 | uence of             | 4  | 1 100  |  |                     |               | MUMMIN                                    |
|          | Examiner  |                | Sequentially list conditions,   | b. ———                                   |   |                      | 0  |  |  |                     |               |   |
|          | p tis   | iner           | ri any, leading to immediate cause. Enter Underlying                            | Due to                                   | (or as a conseq                                 | uence of             | 7).  |  |  |                     |               |   |
| _        | and<br>I-trans  | Examin         | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last   | c  | (or as a conseq                                 | uenco of             | A-   |  |  |                     |               |   |
| 00/00    | ficate be executed<br>physician and<br>is the burial-transit  | E<br>H         |   |  | (or as a conseq                                 | derice of            | <i>)</i> .   |  |  |                     |               |   |
| 00       | ficate<br>g phys  | edical         |   | d  |   |                      |  |  |  |                     |               |   |
| 200      | The law requires that the death certificate be executed ite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit              | 2              | IF FEMALE:<br>23b. Was decedent pregnant  |  | tcome pf pregna                                 |                      |  |  |  | 23d. Date           | of deliver    | v   |
|          | death   | sician/M       | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 4□Preg                                   | birth 2 □ Feta<br>nant at time of d             |                      | 3 ☐ Ectopic pregnancy<br>5 ☐ Other (specify)                                       |  |  | Mont                |               | Day Year                                  |
|          | at the  | Phys           | 9 ☐ Unknown   | 9□Unkn                                   |   |                      |  |  |  |                     |               |   |
| ń        | res th  | ρ              | Part II. Other significant condi  | ighs contributing to d                   | eath but not res                                | ulting in 1          | the underlying cause give  | n in Part I.                                 |  | _                   |               | e cause of death?                         |
| 5        | w require   | ted            |   | The                                      | 50071   |                      |  |  | 1 Tes                                  | 2 No 3              | B ☐ Proba     | bly 4 Unknown                             |
| ב<br>ב   | rsician: The law<br>s certificate has b<br>lirector, page 2 s   | Completed      |   | Suna                                     | re  |                      |  |  | 24a. Was an autopsy                    | pri                 | or to com     | sy findings available pletion of cause of |
| 5        | n: Th<br>ficate<br>rr, pag  |                | 05 11/2-2-2-4   |  |   |                      |  |  | performe<br>1 Yes 2 2                  | No 1E               | ath?<br>Yes 2 | 2□ No                                     |
| <u> </u> | s certii  | o Be           | 25. Was case referred to medic<br>examiner?<br>1 ☐ Yes 2 ☐ No                   | Hospital:                                | Innationt 2 🗆                                   | ED/Outs              | eatient 3 DOA Other  | 26. Place of Death                           |  |                     |               |   |
| 5        | g Phy<br>er this<br>eral d  | <u>⊢</u>       | 27. Manner of Death   | 28a. Date                                | of Injury                                       | 28b. Tir             | me of 28c. Injury  | 4 La Nursing Hom                             | e 5 Residence<br>8d. Describe how      |                     |               | 1   |
| 5        | ath.<br>r: Aft  | atio           | 1 Natural 5 Pendi<br>2 Accident invest  | ng (Mon<br>ligation                      | th, Day Year)                                   | Inj                  |  | es 2 □ No                                    |  |                     |               |   |
| 2        | r Atte<br>er de<br>recto  | Certification: | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide detern                                    | mined   286. Place                       | of injury - At ho                               | me, farn             | n, street, factory, office   | 21   | Bf. Location (Stree<br>City or Town, S | et and Number       | or Rural      | Route Number,                             |
| 2        | ital o<br>Irs aft<br>ral Di   | ခ်<br>ပြ       |   | l ki                                     |   |                      |  |  |  |                     |               |   |
|          | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page | edical         | Check only 21   Medica  | I Examiner: On the b                     | asis of examina                                 | wledge,<br>tion and/ | death occurred at the time<br>for investigation, in my op                          | e, date and place, a<br>inion, death occurre | nd due to the caused at the time, date | se(s) and manr      | ner as sta    | ted.                                      |
|          | the the mple  | Med            | one) 29b. Signature and title of certific                                       | and man                                  | ner stated.                                     |                      | 29c. License   |  |  |                     |               |   |
|          | 0 = 0 =   |                | W-  | - Mo                                     |   |                      |  |  | 290.                                   | Date signed (       | worth, D      | ay, 1ear)                                 |
|          | T wit   |                |   |  |   |                      |  | 1 / 0 7                                      |  |                     | 010           |   |
|          | o D with  | -              | 30. Name and address a new or   |  | e of death /Itom                                | 23a) (T              | vne Print)   | 1-09   |  | 8114                | 010           | >   |
|          | 5   |                | 30. Name and address of perior  | n who completed caus<br>Clen             | of death (Item                                  | 23a) (T              | ype, Print) 18°  | 38 Gre                                       | uno                                    | 8/14<br>Tree        | Pa            | 1 21208                                   |
|          | State Registra  |                | 30. Name and address operior 31. Date filed (Month, Day, Year                   | the S                                    | e of death (Item<br>Ltt (e<br>legistrar's Signa | m                    | ype, Print) 18   | 7569<br>38 Gre                               | une                                    | 8/14<br>(nei        | Pa            | 1 2128                                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2<sup>Day</sup> 2<u>007</u> **Physician** 9, 6:45 PM Donald Francis Durkin August /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 7420 Westlake Terrace #1602 <u>Bethesda</u> Montgomery 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
October 21, 1923 Washington, D.C 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 83 577-12-0214 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Bethesda Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20817 United States 7420 Westlake Terrace #1602 by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "natural", or itel 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Special Agent permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther O'Neill Charles Durkin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12366 Sweetbough Court, N. Potomac, MD 20878 Patrick Durkin / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition August 10. 1 ☐ Burial 2 KI Cremation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 2007 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-21. Signature of Funeral Service Licensee M01473 Chewy Chase, Inc., 7557 Wisconsin Ave., Bethesda, MD 20814 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2 Weeks Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Years Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Surgery and X-Ray Treatment for Parotid Gland Tumor 15 Years Due to (or as a consequence of): ed by the attending physician detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) I Yes 2 □ No 9∐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy 1 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Praminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature a nd title of certifit

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Registrar

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(NO C

AUG I

31. Date filed (Month, Day, Year)

D0053711

August 10, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last)  $10^{\text{Day}}$ Month 08 Physician 2007 2352 Edward Louis Erickson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2□ F 64 10-20-1942 Pennsylvania Director 210-32-0114 Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.

other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location or items 23a or 28a-f show aminer must be notified at Silver Spring 1 ☐ Yes 2 No MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20906 14124 Whispering Pines Dr. #23 Funeral . Was Decedent Ever in U.S. Armed Forces? 152 es 2 No If Yes, Give Year or Dates: 1963 67 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status i "natural", or item: edical Examiner in Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Systems Analyst 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event Be Ethel May Fitton John Erickson ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14124 Whispering Pines Dr. #23 Silver Spring, MD20906 19a. Informant's Name/Relationship (Type. Print) Frances Erickson/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville,MD 8-15-2007 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licer 22. Name and Address of Facility MD20910 Rapp Funeral & Crem.Svc.933 Gist Av.Silver Spring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of): Examiner Perforated Duodenal Ulcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami Multiple Myeloma
Due to (or as a consequence of) and burial Physician/Medical the attending p 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No the 9□Unknown 9 ☐ Unknown signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown End Stage Renal Disease 2 No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 2 No 1 🗌 Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 5 Pending investigation Natural 1 Yes 2 No death. thours after death.

uneral Director: A
ely filled in by the for 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Division or Vital Records, P.O. Box 68760. 2

> Y State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) AUG 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



400645 88

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #1.perMD.g870, 8/15/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Michael Elliott 2 Date of Death 3. Time of Death Year Month **Physician** August 2007 11:40 AM 12 /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAITIMORE HOSPITAL HARBOR If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Year) **X**□ M 2□ F Director 09 69 SC 37 218-88-5223 Usual Residence of Decedent with the Maryland 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show ner must be notified at 1XYes 2 □ No Director Baltimore MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21216 by Funeral 3104 Mondawmin\_Ave Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 'natural", or item dical Examiner 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Emerge Inc. Adult Care 12th grade Ith and Mental Hygid 27 Is marked other of traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Enoch Elliott III Verdel Singleton 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 Is any injury or other trauonce. Verdel Elliott-Mother 21216 3104 Mondawmin ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Pleasant, SC 4 Donation 5 Dother (Specify) 8/18/07 Ocean View 22. Name and Address of Facility 21, Signature of Funeral Service Licensee March F/H West 21216 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Right Cerebral Hemorrahae Physician das disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Completed by Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Sickle Cell Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown stroke 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Seizure Disorder 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Medical Doctor August 12, 2007

State

Registrar

DHMH 17 Rev 1/2001

South Hanover Street,

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

SAIRAH BASHIR

31. Date filed (Month, Day, Year,

AUG I

3001

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death **Physician** 200 /Medical or Location of Death 4c. County of Death Examiner N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep 2, 1946 9. Birthplace (State or Foreign **Funeral** Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 Yes 2 No **Baltimore** Director N/A Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or U.S.A. 21229 913 North Augusta Ave. Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 → No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo Specify. Black Specify ò 3 ☐ Widowed 4 ☐ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Railroad than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, the M Railroad Linesman 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ophelia Edwards John S. English ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2136 West Patapsco Avenue Baltimore, Maryland 21230 Anthony English Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 08/13/07 Baltimore, Maryland Arbutus Memorial Park 4 Donation 5 Other (Specify) 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (nal disease or condition resulting in death) 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Betw Onset and Death Physician /Medical Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a conseque re Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 morans? Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? res 2 No death? 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Inpatient 1 Tyes 2 A 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manne eath 28c. Injury at Work? (Month, Day Year) 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death. To the Funeral Director: After

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

AUG 15

30. Name and address of person who

32 Registrar's Signature 2007

DHMH 17 Rev 1/2001

|                                | Physic<br>/Medi<br>Exami  |
|--------------------------------|---|
| h                              | Funeral<br>Director   |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 te marked other than "natural", or Itema 23a or 28a-1 ehow any injury or other traumatic event, the Medical Examinar must be notified at ODGs. |
|                                | Physician<br>/Medical<br>Examiner   |

| -  | Phy<br>/M<br>Exa   | siciai<br>edica<br>imine   |  |
|--|--|--|--|
| Division of Vital Records, P.O. Box 68760, | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. | To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit |  |
|  | -  |  |  |

| Registrar  |  | C   | Pertificate  | e of D  | eath  |                 | fental Hy  | Reg. No.  | 001  | 4016  |
|--|--|---|--|---|---|-----------------|--|---|--|---|
| Decedent's Name (First, Middle, Last)  | Emma Ek  | ОПОВО   |  |   |   |                 | 2. Date of De.<br>Month  | Day   | Year<br>2007   | 3. Time of Death  |
| 4a. Facility Name (If not institution, give si   |  | OHOMO   | 4b. City.  | Town, or L  | ocation o                                   | of Death        | Augus  | _   | unty of Death  |   |
| Holy Cros  |  | .1  | 12. 0.1,   |   |   |                 |  |   |  |   |
| 5. Social Security Number 6. Sex   |  | e (In yrs. last birthd  | day) If Under  | 1 Year  | If Under                                    | Spri<br>24 Hrs. | 8 Date of Bird   | .h  |  | gomery<br>place (State or Fore  |
| 213-92-0703  | M 2 <b>K</b> ) F   | 84 Yrs  | Months   | Days  | Hours                                       | Min.            | (Month, Da   | y, Year)  | Cou  | Salvador  |
| Usual Residence of Decedent  |  | <u> </u>  |  |   |   |                 | August I   | 0, 102  |  | Barvagor  |
| 10a. State 10b. County   |  | 10c. City, Town o   | r Location   |   |   |                 |  |   |  | 10d. Inside City Limi   |
| Maryland Montgon   | nerv   |   |  | W   | neato                                       | OD.             |  |   |  | 1 Yes 2 X   |
| 10e. Street and Number   | негу   |   | 10f. Zip   |   | leati                                       | OII .           | · · · · · I  | 10a. Citizer  | of What Cou  | intry?  |
|  |  |   | 10.1.2.10  |   | 2000  | 2               |  |   |  |   |
| 4011 Rand  | Olph Koad<br>2. Was Decedent B   |   | 12 Was Dassel  |   | 2090  |                 | anifu Van ar Na  |   | Race - Ameri   | States  |
|  | Armed Forces?  |   | If Yes, spec   | offy Cuban,   | Mexicar                                     | n, Puerto       | ecify Yes or No<br>Rican, etc.)  | 14.   | Black, White,  |   |
| 1 ☐ Never Married 2 ☐ Married  3X Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 📉 N<br>If Yes, Give  | 10  | 1X Yes 2   | 2 □ No  | Specify:                                    | Cal             | vadoran  | Sp  | ecify:   |   |
|  | Year or Dates:   | 1 40- 0   | to the state of the  | 10  |   | Dat             | vauoran  |   | (0)  | White   |
| 15. Decedent's Educ<br>(Specify only highest grade   | ation<br>completed)  | ) (G  | ecedent's Usua<br>Give kind of wor   | rk done dui   | on<br><i>ring mos</i> i                     | t of work       | ing  | 16b. Kind   | of Business/Ir   | ndustry   |
| Elementary/Secondary (0-12)  | College (1-4or 5-  | +) ""   | fe. DO NOT us  |   |   |                 |  |   | 72 - 1. d  | •   |
|  | 2  |   | Se   | eamst   |   |                 |  |   | Fash   | LOn   |
| 17. Father's Name (First, Middle, Last)  |  |   |  | 1   | 8. Mothe                                    | er's Nami       | e (First, Middle,  | Maiden Su   | mame)  |   |
| Anton  | io Vallco  | oto   |  |   | -   |                 | Em   | ma La   | inez   |   |
| 19a. Informant's Name/Relationship (Typ  | e, Print)  | 19b. M  | lailing Address  | (Street and   | d Numbe                                     | er or Run       | al Route Numbe   | or, City or To  | own, State, Zij  | p Code)   |
| Diolinda Ekonomo Mol   | ina/Daugl  | hter 5  | 636 Hop  | enhi.   | 11 T  | erra            | ce, Roc  | kvi11   | e, Mar   | y1and 208   |
| 20a. Method of Disposition   |  | 20b. Place of Di  | isposition (Nam  | ne of   | 1   |                 | Date   |   | ion - City or T  |   |
| 1 Burial 2 Cremation 3 Re  | emoval from State  | Montgo  | crematory or of<br>mery<br>orium I   | tner place)   |   | Aug             | 2007   | D .1  | . 1  | v1  |
| 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License   |  | Cremat  | orium  | inc.  | -4 == -104                                  | Doh             | 2007   | Beth  | esda, I  | Maryland  |
| 21. Signature of Pureral Service License   | / /_   |   | Rocky  | ville   | , In  | c.3             | 00 Vest  | Mont  | gomery   | neral Hom<br>Avenue   |
| 23a. Part1. Enter the disass, or complic   | 1  | M00335  |  |   |   |                 |  |   | 5  |   |
| disease or condition resulting in death)   |  | ssive Ren<br>a consequence of):   |  | lure  |   |                 |  |   |  | Interval Between<br>Onset and Death   |
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Hazel May Etheridge 2007 7:45 P August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 406 Church Street Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 🖫 F Months 87 220 30 1271 Sept. 10,1919 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a, State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Maryland Baltimore Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 406 Church Street 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 X No Specify: 3 ★Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mabel Carneal Walter Drowsky 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Cross Falls Way Sparks, Maryland 21152 James Etheridge / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park | 8/13/2007 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce\_Funeral Service, P.A 21. Signatur Ar ner Srvice Licensee Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1ETASTAT disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24a. Was an

**Physician** /Medical Examiner

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

"natural", or items 23a or 28a-f shov diçal Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Interest of Health and Mental Hygiene. It it item 27 is marked other than "natural", or items 23a or inny or other traumatic event, the Medical Examiner must be nut.

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

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Examiner Physician/Medical Be Completed by Certification: To

Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autonsy perforr 1□ Yes P No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death 5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 1 Tes 2 🗆 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29a. Certifier

1 Naturat

2 Accident

3 ☐ Suicide

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number

0

State Registrar

Medical

VEMULAK 31. Date filed (Month, Day, Year) AUG 1 5 2007



DHMH 17 Rev 1/2001

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within 24 hours after death.

To the Funeral Director: /

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U / 1- State Registrar Amend #7.perFH.g870, 8/1507 TT Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LORENZO EVANS Month Day Year **Physician** 3-30 PM AUGUST 09 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rock Glen Nursing Home Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□ F Hours 77-70 Months Days 277-36-8321 Director May 25, 1930 OH Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "naturel", or items 23s or 28s-f show the Medical Examinar must be notified at MD Baltimore 1 Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 Edgewood Street 21229 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Item eny injury or other traumatic event, the Medical Example 2016. 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2X Married Specify: African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 bartender L'hirondelle Club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alfred Foster Earlee Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Avalee Evans / Wife 717 Edgewood Street; Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. Ce. \* 4 ☐ Donation 5 ☐ Other (Specify) 08/15/2007 Owings Mills, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 638 North Gilmor Street; Baltimore, Maryland 21217 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) stage Kenal Physician /Medical Examiner pertension Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last o (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of deliven 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s 1 ☐ Yes 2 💢 No To the Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 ☐ Yes 2X No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 XNatural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 🛛 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified arau 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | RATA ANDAM BASKARAW 345T W. LKEND AT. Baltimore SAYBANDAY BASKARAN 3457 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 12 per ft 9870 8-15-07 vt
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Marshall tranklin 9,200 467457 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN HOSPITAL BALTO) If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country)

Maryland . Age (In yrs. last birthday) **Funeral** 1-22-321 1 M 2 F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location Baltimore 1 XYes 2 □ No be notified Director Maryland 10f. Zip Code 10g. Citizen of What Country? ò or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status traumatic event, the Medical Examiner Black White etc. 1 ☐ Yes 2 X No // If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) yes 1 and 2 should be filed withi of Health and Mental Hygiene. If item 27 Is marked other than 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SSIC 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra IlVIa 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 □Cremation 3 □R
4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee MD 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed physician and is the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the 9☐Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes 2□ No the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Atter this c 27. Manuer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation within 24 hours after user.

To the Funeral Director: Att 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year) an

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Registrar

31. Date filed (Month, Day,

ORIGINAL

601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

fonth, Day, Year)
AUG 1 5

SHAJH DHARAN

Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Des 4:45A 08 JUANITA FERGUSOL 08 2007 4a Fecility Neme (If not institution, give street end number)
BRINTON WOODS WUYSING & REHAB
1447 BUCK HORN ROAD 4b. City. Town, or Location of Deeth 4c. County of Deeth CAVVOLI SYKESUILLE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Months 1□ M 2□ F 217-20-7786 91 Apr 18. 1916 W Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Carroll Eldersburg 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6003 Cedar Court TISA 21784 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Neme (First, Middle, Lest) 18 Mother's Name (First, Middle, Maiden Surname) Dorce White Mamie Neelv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mr. Harold L. Ferguson (Son) 6003 Cedar Ct., Eldersburg, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Lake View Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 8/13/2007 Sykesville, MD HAIGHT FUNERAL HOME & CHAPEL, P.A. (Box 195 21. Signature of Funeral Service Licensee, Sykesville, MD 21784 (410)-795-1400 MO0764 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) oquelle RULOU Due to (or as a consequence of): Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1□ Yes 2ĒNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes / 2 ☑ No 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 3 Netural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner the attending physician end thed for use es tha burial-trensit Attending Physician: The law requires that the death certificate be executed To the Hospital or Attending Physician: The law requiras thet tha de within 24 hours after death.
within 24 hours after death.
The Funeral Director: After this certificete has been signed by the stompletely filled in by the funeral director, paga 2 should be deteched.

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

permit. Peges 1 and 2 should be filed within 72 hours aftar deeth with the Maryland Department of Heatth and Martial Hygiene. Important: if Item 27 is marked other than "naturel", or items 23s or 28s-f show

Baltimore, Maryland 21215-0036

tem 27 is marked other than "naturel", or frems 23s or 28e-1 show other traumstic event, the Medical Examiner must be notified at

6

Injury

**Physician** 

/Medical

Physician/Medical Examiner

þ

Be Completed

Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

State Registrar

4 Homicide

29b. Signature and tipe of confifie

29a. Certifier (Check only one)

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) ATRICK 31. Date filed (Month, Dey, Yeer) 0 2007



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

20800

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day /Month **Physician** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Gountry) 5. Social Security Number 7. Age (In yrs. **Funeral** Min. Months Days Hours 1 M 2 X F Q16-70-50/ Usual Residence of Decedent Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 Yes 2 No Director more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) Laughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20b. Place of Disposition (Mame of Date 20c. Location - City or Town State 20a. Method of Disposition cemetery, crematory or other place 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) remateryat Loudonl 22. Name and Address of Facility JOSEPH L. KUS 2722 W. North 21. Signature of Funeral Service Licenses Funeral Ne Ba Joseph 2222 23a. Part | Enter the linease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner securities if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s 1∐ Yes To the Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Peath 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, deam occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar th, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 9:50 PM cugust 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOSP, TAL Baltimore Cit or BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours 12-22-6724 1 □ M 2 🗹 F 0 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County items 23a or 28a-f show ner must be notified at 1 □Yes 2 □ No Mary Land Director More 10g. Citizen of What Country? 10f. Zip Code Funeral 12. Was Decedent Ever in Ü.S. Armed Forces 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black White etc. injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 ☐ Divorced lac "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and 2 should be filed within lealth and Mental Hygiene. Elementary/Secondary (0-12) other than nurch Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked ၉ Ohn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 20b. Place of Disposition (Name of cametery, crematory of other place)

Date Baltimore, Pages 1 iment of He 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 113 S 12007 Glen Burnie, Maryland 4 Donation 5 Other (Specify) 21. Signatu of Funeral Service Licensee 23a. Part1. Enfer there sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PANCREATIC CANCER WITH METASTAS S disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown DEMENTIA Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform After this certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 █ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after To the Hospital within 24 hours at To the Funeral I 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 0.0., 76.2. AS2402321 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Hegistrar's Signature AOUN West Belvedere Ave TAU D.a. 2401 31. Date filed (Month, Day, Year) State AUG 1 5 2007 Registrar

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|--|-------------------------|---|---|---------------------------------|--|--|--|--|---|
| /Me  | ician<br>dical<br>niner | 1. Decedent's Name (First, Middle, Last   | nor Fres  |                                 | 4b. City, Town, or   |  | 2. Date of Dea                           |  | III M   |
| Funer<br>Direct  |                         | 5. Social Security Number 6. Se 212-09-9964   | NWSING (<br>7. Age fin yrs.<br>By 89  | entev<br>last birthday)<br>Yrs. | If Under 1 Year<br>Months Days                                   | ff Under 24 H<br>Hours Mi                      | rs. 8. Date of Birt                      | n/a<br>b 9. 1<br>9. 1<br>9. 1<br>9. 1<br>9. 1                        | Birthplace (State or Foreign<br>Country)<br>aryland                         |
| the Maryland<br>28a-f show   | ector                   | 10a. State 10b. County  MD Baltimo  10e. Street and Number  |   | y, Town or Lo                   | 10f. Zip Code  |  |  | 10g. Citizen of What   | 10d. fnside City Limits 1 ☐ Yes 2X No                                       |
| 3a or  | i Dir                   | 1064 Marleigh Circ  | cle   |                                 | 21 204   |  |  | USA  | Country   |
| laryland 21215-0036  2 should be filed within 72 hours after death with the Maryland and Montal Hygiene. Is marked other than "natural", or Items 23a or 28a-1 show aumatic event, the Medical Exacts without be notified at | by Funeral Director     | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced                                   | 12. Was Decedent Ever in U.<br>Armed Forces?<br>1  Yes 2 No<br>If Yes, Give<br>Year or Dates: | 1                               | Was Decedent of Hi<br>f Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No      | ispanic Origin?<br>n, Mexican, Pue<br>Specify: | (Specify Yes or No-<br>erto Rican, etc.) | 14. Race - A<br>Black, W<br>Specify:                                 | merican Indian,<br>hite, etc.<br>White                                      |
| N DOS  | Completed               | 15. Decedent's Edu<br>(Specify only highest grad<br>Elementary/Secondary (0-12)                               | ucation<br>fe completed)<br>College (1-4or 5+)  | (Give                           | dent's Usual Occupa<br>kind of work done o<br>DO NOT use retired | during most of w                               | vorking                                  | 16b. Kind of Busine  | ·   |
| Maryland 2: d 2 should be filed v th and Mental Hygie ?? Is marked other t traumatic event, to   | To Be C                 | 17. Father's Name (First, Middle, Last) Charles Tragese:  | r   |                                 |  | 18. Mother's N<br>Maryar                       | lame (First, Middle,<br>nn Tra           | Maiden Sumame)<br>geser  |   |
| 7 5 € 5 ±  |                         | 19a. Informant's Name/Relationship (T)  Stephanie Myers/da  20a. Method of Disposition                        | aughter   | 1064                            |  |  |  | Maryland   | 21 204  |
| Baltimore, permit. Pages 1 ar Department of Hea Importent: If item any Injury or other   |                         | 1 ⊠ Burial 2 ☐ Cremation 3 ☐ F<br>4 ☐ Donation 5 ☐ Other (Specify)  | Removal from State Par  | emetery, crer<br>ckwood         | cemetery   | 08,  | /16/07                                   | Baltimore  |   |
| Deperment Important  | bouc                    | 21. Signative of Fundar Service Licens 23a. Partil. Enter the disease, or comp                                |   | 1                               | 1050 York  | Road,  | Towson, M                                | laryland   | 21204 Approximate   |
| Physicia<br>/Medic   |                         | shock, or heart faifure. List only o<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | ne cause on each line.<br>a   | men                             | H'a  | g, 3001 a3 card                                | ac or respiratory at                     | 1631,  | Interval Between Onset and Death V-011V5                                    |
| Examine  | er                      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as a conseq  | iluv.                           | e to t   | hriv.  | e<br>disea                               |  | monthy  |
| 8760, <a href="https://doi.org/10.16/07/2016/">8760, <a href="https://doi.org/10.16/">8760, <a href="https://doi.org/">Ansicien and hysicien and the burial-transit</a></a></a>  | lical Examiner          | that initiated events resulting in death) Last  | Due to (or as a conseq  | uence of):                      | 11061  | ung  |  |  | years   |
| .O. Box 68 the death certifical by the attending phy ached for use as th   | Physician/Med           | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh                         | 23c. ff yes, outcome of pregna<br>1 Live birth 2 Feta<br>4 Pregnant at time of d<br>9 Unknown | Ideath 3                        | Ectopic pregnancy Other (specify)                                |  |  | 23d. Date of<br>Month  | delivery<br>Day Year  |
| Cords, P.O. wrequires that the debeen signed by the should be detached   | b                       | Part II. Other significant conditions co  | 1 1 1   | ufting in the u                 | nderlyi <i>n</i> g cause give                                    | en in Part I.                                  |  |  | to the cause of death?  Probably 4 Unknown                                  |
| f VITAL RECORDS, ysician: The law requires t is certificate has been signe director, page 2 should be o  | Completed               |   |   |                                 |  |  | 24a. Was<br>autop<br>perfo<br>1 ☐ Yes    | prior<br>rmęd? death   | autopsy findings available to completion of cause of ? es 2 \( \text{No} \) |
| VIT;<br>sician<br>certifi<br>irector   | o Be                    | 25. Was case referred to medicat examiner?  | Hospital:   | EB/Out-sties                    | Othe   |  | eath (Check only o                       |  |   |
| ng Ph<br>fter th   | _   <b>⊢</b>            | 27. Manner of Death  1 XiNatural 5 Pending 2 Accident investigation   | 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)                                       | 28b. Time of<br>Injury          | 28c. Injury<br>Work  | at   |  | dence 6 Other (S   | респу)  |
| DIVISIO  To the Hospital or Attendi within 24 hours effer death.  To the Funeral Director: A completely filled in by the fu  | Certification:          | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of fnjury - At ho building, etc. (Specif   | y)                              |  |  | City or Tou                              | vn, State)   | Rural Route Number,   |
| the Hosp<br>thin 24 hou<br>the Fune  | Medical                 | 29a. Certifier (Check only one)  2  | sician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated.           | wledge, death<br>tion and/or in | occurred at the time<br>vestigation, in my op                    | oinion, death oc                               | curred at the time,                      | cause(s) and manner<br>date and place, and c<br>29d. Date signed (Mo | due to the cause(s)   |
| F 3 F 8  |                         | 30, Name and address of person who or   | Ompleted cause of death /Item   |                                 |  |  |  |  | 12, 2007<br>and 21227   |
| 5  | State                   | 31. Date filed (Morfin, Day, Year)  | 2 2 2 . 17  | sun 1                           | Avenue   | 150  | Itiniove                                 | . Mary   | and 2122]   |
| Regi   |                         | AUG 1 5 2   |   | 1. A.                           | real ?   |  |  |  |   |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend #26, perMD, g870, 8/15/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Wayne M. Fowlkes 1:20 A. 2007 /Medical August 8 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 406 Morningside Drive Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1**X** M 2□ F 63 Yrs. 214 44 1329 Director Nov. 15, 1943 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23s or 28s-f show must be notified at Maryland 1√ Yes 2 No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1625 Cherry Street 21226 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: r than "natural", or items the Medical Exeminar ma Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify: à Specify: White 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales 12th Florist 5 4 1 other traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lawson Fowlkes Mary Shandrowski ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Jones / Nephew 8 Cromwell Avenue Glen Burnie, Maryland 21061 Health tem 27 Department of Heall Important: If item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 8/10/2007 Baltimore, Maryland 21. Signatur 22. Name and Address of Facility Gonce Funeral Service, P.A. eral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ancar ( wno disease or condition resulting in death) Sminths /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine ettending physicien and I for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗆 No 3 Probably 4 Unknown been si 24a. Was an autopsy performed?
1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? this certificate hes 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours atter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home - Standard 6 Nother Specify S Home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Division 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai

State Registrar

BC. HO, MP 31. Date filed (Mopth, Day, Year) AUG 15 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Type, Print)
3001 S. Hangver St. Baltimore Md

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

07-06197

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Manuel Gomez Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day August 12, 2007 0144 hrs Medical Examiner Manuel G. Gomez 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Good Samaritan Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Months Hours CountryMaryland 08-22-1958 Director 217-76-1420 1 X M 2 F 48 Yrs Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City, Town or Location X Yes 2 23a or 28a-f show notified at once. Baltimore Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 6710 Glenkirk Rd 21239 U.S.A. the s Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 X Married Yes Specify: White Yes If Yes, Give Year 9 Yes 2 No specify: Widowed Divorced ò 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) filed within 72 than more, MD 21215-0036
Pages 1 and 2 should be filed within 72
rent of Health and Mental Hygiene. 12 Contractor Home Improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Manuel A. Gomez Gina M. Wallace 19b. Mailing Address. (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Gina M. Silvestri (Mother) 209 Crocker Drive Apt F Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition Itimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 08-17-2007 |Baltimore, Mar<u>yland</u> Bayview Crematory Donation 5 Other Specify 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc. 610 W. Macphail Rd Bel Air, MD 21014 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line Death /Medical a. Hanging Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit /sician/Medical AMENDED LINPENDED ned by the attending physician detached for use as the burial The law requires that the death certificate be Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.O. contributing to death but not resulting in the underlying cause given in Part I. page 2 should be detache Yes 2 ✓ No 3 Probably 4 Unknown Ş Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? certificate has Yes 2 ✔ No 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Division of Vital Be Hospital: 1 examiner? Other<sub>4</sub> Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA this 1 ✓ Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury After 27. Manner of Death Subject hanged self Certification: FOUND: Yes 2 V No Natural filled in by the f Pending 24 hours after death. Aug 12, 2007 0021 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 6207 Everall Ave., Baltimore, Md. (Specify) Single Family determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 12, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Carol Allan, MD 31. Date filed (Month, Day, 32. Registrar's Signature State

ORIGINAL

Registrar

|                |  |                | 1 - State<br>Registrar   |   | artment of Health and rtificate of Death  | R  | eg. No. Z 007                                  | 26135  |
|----------------|--|----------------|--|---|---|--|--|--|
| ľ              | Physicia<br>/Medic   |                | 1. Decedent's Name (First, Middle, Last)  Ida M. Gunn  |   |   | 2. Date of Deal<br>Month<br>August       | <sup>Day</sup> 0,2007                          | 3. Time of Death 10:30 pM                          |
|                | Examin   |                | 4a. Facility Name (If not institution, give street and number)  Manor Care-Rossville   |   | 4b. City, Town, or Location of Deat Rossville   | h  | 4c. County of Death Baltimo:                   |  |
|                | Funeral<br>Director  |                |  | yrs. last birthday)<br>98 Yrs.                  | If Under 1 Year If Under 24 Hrs Months Days Hours Min.  | 8. Date of Birth<br>Month Day<br>Aug 1 2 | 9. Birth                                       | place (State or Foreign                            |
|                | Maryland<br>a-f show<br>ified at   | ctor           | Usual Residence of Decedent  10a. State 10b. County 10c  MD Baltimore  | c. City, Town or Lo<br>Midd]                    | le River  |  |  | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No             |
|                | h with the<br>23a or 28a<br>st be not  | al Director    | 10e. Street and Number 1116 Stephen Drive  |   | 10f. Zip Code<br>21 2 2 0   | 1  | Og. Citizen of What Cou<br>USA                 | intry?   |
| 936            | should be filed within 72 hours after death with the Maryland nd Mental Hyglene. I marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23b or 28a-f show marked other the Medical Examiner must be notified at   | by Funeral     | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:   |   | Was Decedent of Hispanic Origin? (\$<br>If Yes, specify Cuban, Mexican, Puer<br>1 ☐ Yes 2 ☑ No Specify: | pecify Yes or No-<br>to Rican, etc.)     | 14. Race - Amer<br>Black, White<br>Specify: Wh | , etc.   |
| 1215-0036      | within 72 horener. than "natur. he Medical E   | Completed      | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  7th  College (1-4or 5+)  | (Give   | dent's Usual Occupation kind of work done during most of wo DO NOT use retired)  emaker                 | rking                                    | 16b. Kind of Business/loown home               | ndustry  |
| and 2          | should be filed wind Mental Hygien marked other the matic event, the   | Be             | 17. Father's Name (First, Middle, Last)  Dow Mullins   |   |   | me (First, Middle, i                     | ,  |  |
| Maryland 2121  | nd 2 shoul<br>Ith and Me<br>27 Is mark<br>traumati   | ၉              | 19a. Informant's Name/Relationship (Type. Print) JOhn Davis /grandson  | 1   | ng Address (Street and Number or R  | ural Route Number                        | r, City or Town, State, Z                      | • '  |
| altimore,      | permit. Pages 1 and 2 should be<br>Department of Health and Menta<br>Important: If item 27 Is marked<br>any injury or other traumatic ev<br>once.  |                | 20a. Method of Disposition  1 XBuriat 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)   | 0b. Place of Dispo<br>cemetery, crer<br>Holly H | osition (Name of<br>matory or other place)<br>Hill Cemetery   | Date<br>3/14/07                          | 20c. Location - City or T                      |  |
| Balti          | permit. Departn Importa any inju   |                | 21. Signatus Funeral Service Licensee  | 14 22   | 2. Name and Address of Facility 3 Connelly Fune   | 00 Mace                                  | Ave.Balto                                      | O. MD<br>x 21221                                   |
|                | Physician  | a ja           | 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition   | death. Do not ent                               | ter the mode of dying, such as cardia   | c or respiratory arr                     | rest,  | Approximate<br>Interval Between<br>Onset and Death |
| 1              | /Medical<br>Examiner   |                | resulting in death)  Due to (or as a col   | ul F  | ashlata   |  |  |  |
| 1              | ecuted<br>tnd<br>transit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a condition of the c | Sonver  | Men Azurd   | ent                                      |  |  |
| 68760,         | cate be ex<br>physician a<br>the burial.   | edical E       | d. (tr   | 0.  | man   |  |  |  |
| P.O. Box 6     | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown  | Fetal death 3                                   | ⊒Ectopic pregnancy<br>□ Other (specify)   |  | 23d. Date of deli<br>Month                     | very<br>Day Year                                   |
| ds, P.         | uires that or signed by Id be deta   | þ              | Part II. Other significant conditions contributing to death but no   | _   |   | 23e. Did to                              | bacco use contribute to                        | the cause of death?                                |
| Vital Records, | The law req<br>ate has beer<br>page 2 shou   | Completed      | Hasting of Deep  | Ven   | ym posis  | 24a. Was a autops perfor                 | sy prior to c                                  | topsy findings available ompletion of cause of     |
| r Vita         | ysician:<br>tis certifica<br>director,   | To Be C        | 25. Was case referred to medical examiner?  1 \[ Yes \] 2 \[ \] No \[ Hospital: 1 \[ \] Inpatient  | 2 ER/Outpatier                                  | Other   | ath <i>(Check only or</i>                | ence 6 Other (Spec                             | sify)  |
| Division or    | Attending Physician: The sr death. ector: After this certificate he by the funeral director, page  |                | 27. Manner of Death 1 Natural 5 Pending (Month, Day Ye. 2 Accident investigation   | ar) 28b. Time o                                 | of 28c. Injury at Work?  M 1 Yes 2 No   | 28d. Describe h                          | ow injury occurred                             |  |
| DIVIO          | tal or Att   | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury building, etc. (S   |   | reet, factory, office   | 28f. Location (S<br>City or Tow          | treet and Number or Ru<br>n, State)            | ral Route Number,                                  |
|                | To the Hospital or<br>within 24 hours afte<br>To the Funeral Dir<br>completely filled in   | Medical        | 29a. Certifier (Check only one)  1 Sertifying Physician: To the best of my and manner stated.  |   | nvestigation, in my opinion, death occ  | curred at the time, o                    | date and place, and due                        | to the cause(s)                                    |
| )              | With Coordinates   | 2              | 29b. Signature and title of certifier  |   | 29c. License number D3144   |  | 29d. Date signed (Month                        | () Day, Year)                                      |
|                | +  |                | 30. Name and address of person who completed cause of death SHOR113 A. HAS MM  | 8211  |   | Sonta                                    | 308 130  | Ut me MI   |
|                | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year) 32. Registrates  | Signature                                       |   |  |  | 72 (2  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Glenn C. Goins 2007 8:45 A. M August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Queen Annes 6 Petinot Court Stevensville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 220 66 6047 50 Director Feb. 16, 1957 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 1 ☐ Yes 2 👿 No Stevensville Director Maryland Queen Annes 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 Petinot Court 21666 U.S.A. Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 👿 If Yes, Give Year or Dates: 1 Never Married 2K Married 2 🛛 No Saltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0.P.S. Teamster 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Glenn Goins Jean Ketterman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Goins / Wife 6 Petinot Court Stevensville, Maryland 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 A Burial 2 ☐ Cremation 3 ☐Removal from State Glen Haven Mem. Park 8/14/2007 | Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Esylhegezl CENU disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and for use as the burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 1□ Yes 2□ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 041339 08-13-2007

DHMH 17 Rev 1/2001

Registrar

JAMIC

31. Date filed (Month, Day, Year)

STEVENBULLE

SALLITT DLIKE

He distrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10: 15 PM AUGUST 13 2007 IRINA GENINA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ba Univ. more | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 09/25/1927 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** KIEV 1 □ M 2 □ F 79 Director 216-41-9657 Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits show 1 □Yes 2 No r 28a-f sh notified MD BALTIMORE BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r items 23a or 2 liner must be n UKRAINE 3 COBBLESTONE COURT APT. 2-A 21215 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify WHITE Specify: 3 Widowed 4 Divorced Genina, Irina er than "nature, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **PSYCHIATRIST PSYCHIATRY** 5+ 7 is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be POLIKOV GENINA ROZINA **JACOB** 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12264 BONMOT PLACE - REISTERSTOWN, MD 21136 YURIY TRESKUNOV / SON item 27 i permit. Pages 1 and Department of Health Important: If item 27 any Injury or other trooper. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE HEBREW CONG 08/14/2007 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 700 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** YN Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner berteus or Sequentially list conditions, if any, leading to in modal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam ingu Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1 Yes 2 ☑ 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1\_Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 200 per Debastrent of Health and Mental Hygiene

Registrar

State

AUG 1 5 2007 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

· cprietta NO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c, License number

D 34974

29d. Date signed (Month, Day, Year)
August, 13 2007

|             |  |                                  | 1 - State<br>Registrar   |   | artment of Healtl<br>rtificate of Deal  | th  | Reg. No.   |  |  |  |  |  |  |
|-------------|--|----------------------------------|--|---|---|---|--|--|--|--|--|--|--|
|             | Physicia   |                                  | 1. Decedent's Name (First, Middle, Last)  Edward M. Howell   |   |   | 2. Date of<br>Augus                           |  | 3. Time of Death                                     |  |  |  |  |  |
|             | /Medic<br>Examin   |                                  | 4a. Facility Name (If not institution, give street and number) 618 W. Kingsway Road  |   | 4b. City, Town, or Location  Middle F   |   | 4c. County of De   | ath  |  |  |  |  |  |
| 19.         | Funeral<br>Director  | al Director                      | 5. Social Security Number 6. Sex 1½ M 2 □ F 7. Age (i  | n yrs. last birthday)<br>73 Yrs.              |   | der 24 Hrs. 8. Date of (Month                 | Birth 9. B   | Birthplace (State or Foreign Country)                |  |  |  |  |  |
| III         | yland<br>now<br>at   |                                  |  | 0c. City, Town or Lo                          |   |   | 141  | 10d. Inside City Limits                              |  |  |  |  |  |
| 36          | he Mar<br>8a-f st<br>otified   |                                  | MD Baltimore   | Middl   | le River  |   | 40- 011  | 1 ☐ Yes 2 🛣 No                                       |  |  |  |  |  |
|             | h with t   |                                  | 10e. Street and Number 618 W. Kingsway Road  |   | 10f. Zip Code 21220   |   | 10g. Citizen of What 0   | Sountry?   |  |  |  |  |  |
|             | in 72 hours after death with the Maryland<br>"natural", or Items 23a or 28a-f show<br>ledical Examiner must be notified at   | by Funeral                       | 11. Marital Status  1 □ Never Married 2√2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Eve Armed Forces?  1 □ X e S ∈ S ∈ No If Yes, Give Year or Dates:  |   | Was Decedent of Hispanic<br>If Yes, specify Cuban, Mex<br>1 ☐ Yes 2X No Spec    |   |  | nerican Indian,<br>nite, etc.<br>White               |  |  |  |  |  |
| 15-0036     |  |                                  | 15. Decedent's Education<br>(Specify only highest grade completed)   | 16a. Dece                                     | dent's Usual Occupation<br>kind of work done during r<br>DO NOT use retired)    | most of working                               | 16b. Kind of Business/Industry                                       |  |  |  |  |  |  |
| 717         | be filed within tal Hygiene. d other than 'event, the Me   | Completed                        | Elementary/Secondary (0-12) College (1-4or 5+) 12th  | Groc  | cery Manage   | er  | Metro  |  |  |  |  |  |  |
| and         | uld be file<br>fental Hy<br>rked othe<br>tic event,  | Be                               | 17. Father's Name (First, Middle, Last)  Henry Howell  |   | 18. M   | lother's Name <i>(First, Mid</i><br>Hazel Mod |  |  |  |  |  |  |  |
| aZ          | ages 1 and 2 should be<br>ant of Health and Mental<br>t: If item 27 Is marked of<br>y or other traumatic eve   | ပို                              | 19a. Informant's Name/Relationship (Type. Print)   | 19b. Mailir                                   | ng Address (Street and Nu   |   |  | , Zip Code)  |  |  |  |  |  |
| Ž           | l and 2<br>lealth a<br>m 27 k  | 1                                | Loretta Howell /wife   |   | 518 W. King   |   | Baltimor   |  |  |  |  |  |  |
| galtimore,  | permit. Pages 1 Department of H Important: If ite any injury or ot   |                                  | 4 Donation 5 Dotner (Specify)  |   | osition (Name of matory or other place) Vn Cemetery                             |   | Baltimo  | re MD  |  |  |  |  |  |
| g           | permi<br>Depa<br>Impo<br>any ir  | . 13                             | 21. Signature Funeral Service Licensee   | 7   | 2. Name and Address of Fa   | 300 MAG<br>Juneral Ho                         | ce Ave. Ba   |  |  |  |  |  |  |
|             | Physician  | 100                              | 23a. Part1. Enter the disease, or complications that caused ble death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Approximate Interval Betwee Onset and Deat Interval Betwee Onse |   |   |   |  |  |  |  |  |  |  |
|             | /Medical<br>Examiner   |                                  | resulting in death)  Due to (or as a continuous continu |   |   |   | 2,5 years  |  |  |  |  |  |  |
| P           | p ±  | iner                             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)   | consequence of)                               |   |   |  |  |  |  |  |  |  |
| ر<br>کر     | ificate be executed<br>g physician and<br>as the burial-transit  | I Examiner                       | Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a continuous c         | onsequence of):                               |   |   |  |  |  |  |  |  |  |
| 08/PU       | ficate by physicas the part of | edical                           | d  |   |   |   |  |  |  |  |  |  |  |
| O. BOX      | atth cert<br>attending<br>for use a  | Physician/M                      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf 1 □ Live birth 2 in 4 □ Pregnant at tire 9 □ Unknown  | Fetal death 3                                 | □Ectopic pregnancy<br>□ Other (specify)   |   | 23d. Date of o   | lelivery<br>Day Year                                 |  |  |  |  |  |
| 7.          | w requires that the de<br>been signed by the<br>should be detached   | by Phy                           | Part II. Other significant conditions contributing to death but  | not resulting in the u                        | nderlying cause given in Pa   | 'art I. 23e. [                                | Did tobacco use contribute   | to the cause of death?                               |  |  |  |  |  |
| Records,    | require<br>een sig<br>hould b  | Certification: To Be Completed b |  |   |   |   |  | Probably 4 ☐Unknown                                  |  |  |  |  |  |
|             | (C) (C)  |                                  |  |   |   | 8   | autopsy prior to<br>performed? death                                 | autopsy findings available o completion of cause of? |  |  |  |  |  |
| VItal       | lysician:<br>is certific<br>director,  |                                  | 25. Was case referred to medical examiner?  1  Yes   | 2 □ FB/Outpaties                              | Othori  | olly one)                                     |  |  |  |  |  |  |  |
| Division or | ig Phy<br>ter this<br>neral d  |                                  | 27. Manner of Death 28a. Date of Injury  | To inpatient 2 Envoupatient 3 DOA 4 Nursing H |   |   | ome 5 Residence 6 Other (Specify)  28d. Describe how injury occurred |  |  |  |  |  |  |
|             | To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Af completely filled in by the fun  |                                  | 3 Sulcide 6 Could not be<br>4 Homicide determined 28e. Place of injury<br>building, etc.   | 28f. Locati<br>City of                        | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |   |  |  |  |  |  |  |  |
|             | Hospi<br>24 hour<br>Funer<br>stely fill  | edical                           | 29a. Certifier (Check only one)  Check only one)  Check only one)  Check only one)  Medical Examiner: On the basis of examt manner state   | xamination and/or in                          |   |   |  |  |  |  |  |  |  |
|             | To the within To the comple  | Med                              | 29b. Signature and the of certifier  |   | 29c. License numb   |   |  | 29d. Date signed (Month, Day, Year)                  |  |  |  |  |  |
| )           |  |                                  | · Cunclelatif  | 1 /// 52 \ -                                  | 1)2433  | 56  | Hugust 1   | 3, 200 7   |  |  |  |  |  |
|             | -10  |                                  | 30. Name and address of person who completed cause of dear   | d 910   | 3 Frank   | lin Squar                                     | e Drive Ste  | 18 COPP.   |  |  |  |  |  |
| 0           | Sta<br>Registr   |                                  | 31. Date filed (Month, Pay, Year) 32. Registrar's  | Signature                                     | 20  | 1   |  |  |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 6:39 AM 2007 /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 60610 If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Ceuntry) Social Security Number **Funeral** Months Days Min. 1□M 2XF Hours Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits aral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any Injury or other traumatic percentage. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced ac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6) and 20b. Place of Disposition (Name o cemetery, crematory or other pate 20c. Location - City or Town, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State Balto Cremetory at 2. Name ind Address of Facility 21. Signature of Funeral Service License MARYA 23a. Part l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedial Cause (Final disease or condition resulting in death) **Physician** Hage PULLANDGEFICIERY /Medical Due to (or as a consequence of): **Examiner** Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 🗌 No 3 Probably 4 ∭Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) after death. 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0

State Registrar

tate 31. Date filed (Month, Day, Year) trar AUG 1 5

30. Name and address of person who completed caus

2007

32. Signature

death (Item 23a) (Type, Print)

Spertie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrer Amend 11,19a, perFH, g870, 8/15/07 TICertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 01:16(AM Hines-Sydnor Alma August 2007 Joyce /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospital Battimore City Ballimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2√F Yrs 46 Director 212-70-6847 31 60 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √Yes 2 No Director NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3413 Grantley U.S.A.

14. Race - American Indian,
Black, White, etc. Funeral Road 21215 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes No If Yes, Give Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th grade 2yrs Secretary Jandoll Electronics 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nathaniel Hines Alma Maberey 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Claude Lee Syden Jr.-Husband 3413 Grantley Road, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory Inc 8/14/07 Baltimore, Md Metro 21. Signature of Funeral Service Licentee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (fundal **Physician** andida 22 days /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 4□Pregnant et time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Dancicatins TON 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? DVIS IVC filter 24a. Was an has autopsy perform 1 Yes 2 Renal 1 Yes 2 No certificate Fallure Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 10 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai C-Unuoha MID

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

1

neck

32 degistrar's Signature

07-06177 Tamera Hill Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| amera niii   | 1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death  | 2001 2614   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| Physician  | 1. Decedent's Name (First, Middle Last)  2. Date of Death  | 3. Time of Death                                  |  |  |  |  |  |  |  |
| Medical Examine  | 4a. Facility Name (if not institution, give street and number)  Month August 11, 2   | 2007 0835 hrs                                     |  |  |  |  |  |  |  |
| ,  | Sinai Hospital  Baltimore City   | AC. County of Death                               |  |  |  |  |  |  |  |
| Funeral<br>Director  | Months Days Hours Min AC   | (MM/DD/YYYY) 9. Birthplace (State or Foreign      |  |  |  |  |  |  |  |
| Director   | Usual Residence of Decedent  Usual Residence of Decedent   | -1964 Country) Md,                                |  |  |  |  |  |  |  |
| ' any  | 10a. State 10b. County 10c. City, Town or Location   | 10d. Inside City Limits                           |  |  |  |  |  |  |  |
| yland<br>-f shov   |  | 1 VYes 2 No                                       |  |  |  |  |  |  |  |
| hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once and by Furnbral Director | 10e. Street and Number 906 N. Bentalov St 10f. Zip Code 2,216  | . Citizen of What Country?                        |  |  |  |  |  |  |  |
| or items 23  | 11. Maritar Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)   | 14. Race - American Indian, Black,<br>White, etc. |  |  |  |  |  |  |  |
| s after de   | 3 Widowed 4 Divorced If Yes 2 No 1 Yes 2 No specify: or Detection  | Specify: Slack                                    |  |  |  |  |  |  |  |
| hours<br>maturi<br>Exami   | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   | 6b. Kind of Business/Industry                     |  |  |  |  |  |  |  |
| 5-0036 led within 72 hour. Hygiene. other than "uatu   | Elementary/Secondary (0-12) College (1-4 or 5+)  NIA NEVEL WORKE A.  | NA  |  |  |  |  |  |  |  |
| T =  |  | 0 1   |  |  |  |  |  |  |  |
| 2121 2121 ould be fi d Mental I s marked ic event,   | 19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number)  | 100   |  |  |  |  |  |  |  |
| MD<br>nd 2 sho<br>alth and<br>m 27 is<br>aumati  | Delores Hill - mother 1906 N. Bentalw St. B  | Balto and 21216                                   |  |  |  |  |  |  |  |
| Ore,<br>ges l ar<br>t of Her<br>i If ite   | 1 Burial 2 Cremation 3 Removal from State crematory or other place)  | 20c. Location - City or Town, State               |  |  |  |  |  |  |  |
| Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tri  | 4 Donation 5 Other Specify: 1  21. Signature of Fune 4 Service Licensee 22. Name and Address of Facility 270 frod  | Deendalk, ud.                                     |  |  |  |  |  |  |  |
| E E E E  | South I fant Gary P. warch French  | ral Horre Butto, nel 212                          |  |  |  |  |  |  |  |
| Physician<br>/Medical  | 23a Pah). The the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest fail in List only one cause on each line.   | Between Onset and                                 |  |  |  |  |  |  |  |
| Examiner   | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Death  Due to (or as a consequence of):   |   |  |  |  |  |  |  |  |
| <u>.</u>   | Sequentially list conditions. b.   |   |  |  |  |  |  |  |  |
| led<br>nisit<br>Examiner   |  |   |  |  |  |  |  |  |  |
| ecuted and - transit   |  |   |  |  |  |  |  |  |  |
| '60, ate be execu physician and he burial - tra  | X UNPENDED AMENDED 27,28a-f, perME,g871, 9/19/07 TT  |   |  |  |  |  |  |  |  |
| Box 68760, e death certificate be exemple attending physician ed for use as the burial-hysician/Medic:                             | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  | 23d. Date of delivery  Month Day Year             |  |  |  |  |  |  |  |
| b. Box 687 the death certific by the attending p ched for use as the   | 4  |   |  |  |  |  |  |  |  |
| cords, P.O. Boy aw requires that the death as been signed by the att 2 should be detached for professional by Physis               |  | acco use contribute to the cause of death?        |  |  |  |  |  |  |  |
| S, P.( uires tha n signed d be det   | 1 Yes  | 2 No 3 Probably 4 Unknown                         |  |  |  |  |  |  |  |
| Records, The law require fricate has been signage 2 should be  | 24a. Was an autopsy  | prior to completion of cause of                   |  |  |  |  |  |  |  |
| tal Recition: The certificate rector, page   | 1 Yes 2 1 25. Was case referred to medical 26.Place of Death (Check only one)  |   |  |  |  |  |  |  |  |
| Vital  Thysician  This cert  Ithis cert  Ithis cert  To Be   | examiner?  | esidence 6 Other:                                 |  |  |  |  |  |  |  |
| n of V<br>ding Ph.<br>After th<br>funeral  | 27. Manner of Death 28a. Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Work? 28d. Describe how  | w injury occurred                                 |  |  |  |  |  |  |  |
| Sion Attence or death cector: by the   | 2 Accident Investigation   Find 8/11/2007   unk   1 to 3 A. No Unk   1 | eet and Number or Rural Route Number, City        |  |  |  |  |  |  |  |
| Division o<br>spital or Attending<br>tours after death,<br>neral Director: Aft<br>filled in by the fune<br>Certification:          |  | te)<br>Heights Ave. Baltimore, MD                 |  |  |  |  |  |  |  |
| 0 - = 0  | 2ga. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(sone)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date an   | ·   |  |  |  |  |  |  |  |
| To the II. within 24 To the Fi completel   | and manner stated.   | 29d. Date signed (Month, Day, Year)               |  |  |  |  |  |  |  |
|  | Mayra medhul o.c.m.E.  | August 12, 2007                                   |  |  |  |  |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201   |   |  |  |  |  |  |  |  |
| State  | 31. Date filed (Month_Day, Year) 32. Sqistrar's Signature  |   |  |  |  |  |  |  |  |
| Registra   | AUGI 5 2007 Resear & species   |   |  |  |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Dorothy 6:00p. /Medical Henson-Mayes August 8 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randallstown Baltimore Future Care Nursing Home 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F Yrs. 91 Director 212-01-2870 Usual Residence of Decedent 12 05 VA permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 √Yes 2 No Directo MD Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 U.S.A. 4108 Fords Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2√2 No Specity Completed by Specity: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specity only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ೭ Mary Comfort Alfred Speaks 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Woodland-Daughter 1711 Darley Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specity) 8/16/2007 Zion Baltimore, Md 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed lase physician and s the burial-trans Due to (or as a consequence of Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Year Day 5 ☐ Other (specity) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 0 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy s certificate ha 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specity) 1 ☐ Yes 2 No P 1 inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) Director: After the in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001 BALASUBRAI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVANAN

31. Date filed (Month, Day, Year)

65046

1 - For Stata Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show

Hayes. Kenneth Limes

Baltimore, Maryland 21215-0036

Physic /Med

Exam To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

|                      |  | 4a. Facility Name (If not institution, give street and number)  Prince Georges Medical Center  |            |   |                                       |   |  | 4b. City, Town, or Location of Death   |            |             |                                  |                                 | nty of Dea                            |   |  |  |  |
|----------------------|--|--|------------|---|---------------------------------------|---|--|--|------------|-------------|----------------------------------|---------------------------------|---------------------------------------|---|--|--|--|
|                      | 5. Social Security   |  | Med 1      |   | enter<br>7. Age (In yrs               | la et hirtl   | nday)  | CHev<br>f Under 1 Year   | rerly      | r 24 Hrs.   | 8. Date of Birtl                 |                                 |                                       | eorges  |  |  |  |
|                      | 579-78-6   |  |            | M 2□F   |                                       |   |  | onths Days   | Hours      | Min.        | (Month, Day                      | , Year)                         |                                       | thplace (State or Foreig                          |  |  |  |
|                      | Usual Residence  |  |            |   | 52                                    | ·   |  |  | <u></u>    | 1           | May 20,                          | 1955                            | Wası                                  | nington, DC                                       |  |  |  |
|                      | 10a. State   | 10b. County  | у          |   | 10c. C                                | ity, Town   | or Locat   | ion  | -          |             |                                  |                                 |                                       | 10d. Inside City Limit                            |  |  |  |
| ö                    | MD   | Prince   | a Car      | 7000  |                                       | Cani  | to1  | Heights  | 2          |             |                                  |                                 |                                       | 1 X Yes 2 □ N                                     |  |  |  |
| Director             | 10e. Street and No   | rges   |            | Oapı  | LOI                                   | 10f. Zip Code   |  |  |            | 10a Citizen | g. Citizen of What Country?      |                                 |                                       |   |  |  |  |
| ā                    |  |  |            |   |                                       |   |  |  |            |             |                                  |                                 |                                       |   |  |  |  |
| Funeral              | 5106 Due1 Place  |  |            |   |                                       |   |  | 2074   |            | rigin? (Co. | noify Voc or No                  | USA 14. Race - American Indian, |                                       |   |  |  |  |
| Ų,                   | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?   |  |            |   |                                       |   |  | es, specify Cubi   | an, Mexica | an, Puerto  | ecify Yes or No-<br>Rican, etc.) | E                               | Black, White, etc.                    |   |  |  |  |
| þ                    |  |  |            |   |                                       |   |  | 1 ☐ Yes 2 <b>X</b> No <i>Specify</i> :   |            |             |                                  |                                 | Specify: Black                        |   |  |  |  |
|                      |  |  |            |   |                                       |   |  |  |            |             |                                  | Rusiness                        | /Industry                             |   |  |  |  |
| let                  | (Specify only highest grade completed)   |  |            |   |                                       |   | (Give kind of work done during most of working life. DO NOT use retired) |  |            |             |                                  |                                 | Top. Ising a pasilosa maasty          |   |  |  |  |
| Completed            | Elementary/Secondary (0-12) College (1-4or 5+)   |  |            |   |                                       |   | Tele Marketer  |  |            |             |                                  |                                 | Pvt.                                  |   |  |  |  |
| e Co                 | 12<br>17. Father's Name  | (First. Middle   | , Last)    |   | · · · · · · · · · · · · · · · · · · · | 1   | CIE  | HULKEL   |            | ner's Name  | e (First, Middle,                |                                 |                                       |   |  |  |  |
| œ                    |  | Walter   |            | Jes   |                                       |   |  |  |            |             | nel Rich                         |                                 |                                       |   |  |  |  |
| 은                    |  |  | •          |   |                                       | 101   | MACIFIC .  | Address (Ct  |            |             |                                  |                                 |                                       | Zin Codel   |  |  |  |
|                      | 19a. Informant's N   |  | _          | •   |                                       |   |  |  |            |             | Al Route Numbe                   |                                 |                                       |   |  |  |  |
|                      | Margaret   |  | WIIE       | <u> </u>  | 201                                   |   |  |  | 100        |             | ol Heigh                         |                                 |                                       | 743   |  |  |  |
|                      | 20a. Method of Di  | sposition<br>Cremation   | 3 ∏R       | emoval from   | State 200.                            | cemeter)  | uspositi<br>, cremat   | on (Name of<br>ory or other plac   | ce)        | L           | Date                             | Zuc. Locatio                    | on - City of                          | Town, State                                       |  |  |  |
|                      |  | 5 ☐ Other (  |            |   |                                       | esape   |  |  | _          | -           |                                  |                                 |                                       | 11e, MD   |  |  |  |
|                      | 21. Signature of F   | uneral Service   | License    | 9/  |                                       |   | 22. N  | ame and Addre  | ss of Faci | lity AGE    | EE/MCKIN                         | INON F                          | unera                                 | 1 Service   |  |  |  |
|                      |  | and  | 4          | H   |                                       |   | 3821   | 14th S   | STree      | t, N        | I, Washi                         | ngton                           | , DC                                  | 20011   |  |  |  |
|                      | 23a. Part1. Enter  | the disease, o   | or complic | cations that c  | aused the dea                         | th. Do n  | ot enter   | he mode of dyir  | ng, such a | s cardiac o | or respiratory ar                | rest,                           |                                       | Approximate<br>Interval Between                   |  |  |  |
|                      | Immediate Cause  | art fællure. Lis<br>(Final   | t only on  |   | EPTIC                                 | ,   | = MG   | 304151   | 1          |             |                                  |                                 |                                       | Onset and Death                                   |  |  |  |
|                      | disease or conditi<br>resulting in death   | ion  | a          |   | or as a conse                         |   |  | 102131   | 1          |             |                                  |                                 |                                       | 30 9912   |  |  |  |
|                      |  |  |            | En  | or as a conse                         | o C   | Dear   | 0 1:   | Som        | 10          |                                  |                                 |                                       | 3 VYS   |  |  |  |
| er                   | Sequentially list conditions, if any, leading to immediate  b. Due to (of as a consequence of):  Due to (of as a consequence of):  Due to (of as a consequence of):  |  |            |   |                                       |   |  |  |            |             | 7113                             |                                 |                                       |   |  |  |  |
| u lu                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |  |            |   |                                       |   |  |  |            |             |                                  | 20 days                         |                                       |   |  |  |  |
| Examin               | Cause (Disease or injury that initiated events c. Preumente of):  Due to (or as a consequence of):   |  |            |   |                                       |   |  |  |            |             |                                  | ~ 75                            |                                       |   |  |  |  |
|                      |  |  |            |   |                                       |   |  |  |            |             |                                  |                                 |                                       |   |  |  |  |
| dic                  |  |  | d.         |   |                                       |   |  |  |            |             |                                  |                                 |                                       |   |  |  |  |
| cian/Medical         | IF FEMALE:   |  | 21         | 3c If yes out   | come of acc                           | 2000  |  |  |            |             |                                  |                                 |                                       |   |  |  |  |
| lan/                 | 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1  |  |            |   |                                       |   |  |  |            |             | blivery<br>Day Year              |                                 |                                       |   |  |  |  |
| sici                 | 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)   |  |            |   |                                       |   |  |  |            |             |                                  |                                 |                                       |   |  |  |  |
| Phys                 | 9 Unknown  |  |            |   |                                       |   |  |  |            |             |                                  | a the second of the second      |                                       |   |  |  |  |
| by P                 | Part II. Other significent conditions contributing to death but not resulting in the u   |  |            |   |                                       |   |  |  |            |             |                                  |                                 | use contribute to the cause of death? |   |  |  |  |
|                      |  |  |            |   |                                       |   |  |  |            | 121         | 1  Yes 2 No 3 Probably 4 Unknow  |                                 |                                       |   |  |  |  |
| plet                 |  |  |            |   |                                       |   |  |  |            |             | 24a. Was                         | an 24                           | b. Were a                             | utopsy findings availab<br>completion of cause of |  |  |  |
| ٦                    |  |  |            |   |                                       |   |  |  |            |             |                                  | rmed?                           | death?                                |   |  |  |  |
| ошр                  | 25. Was case refe  | erred to medic   | al         |   |                                       |   |  |  | 28 Plan    | ce of Death | 1 ☐ Yes                          | 2 No                            | 10                                    |   |  |  |  |
| e Completed          | examiner?  | No   | _          | ospital:  | npatient 2[                           | ☐ ER/Out  | nationt  | 3□ DOA Ott   |            |             | me 5 ☐ Resid                     |                                 | Other /Sc                             | acifu)  |  |  |  |
| Be                   | 27. Manner of Dea  |  |            |   | of Injury<br>th, Day Year)            | 28b. T  |  | 28c. Injur   | ry at      |             | 28d. Describe h                  |                                 |                                       | y/  |  |  |  |
| To Be                | 1 Natural  | 5 🗆 Pendi  |            | (Mon  | h, Day Year)                          |   | jury   |  |            |             |                                  | . , , , ,                       |                                       |   |  |  |  |
| To Be                | 2 Accident investigation  3 Suicide 6 Could not be 20 Discrete from the control of the could not be 20 Discrete from the could not be 20 Discr |  |            |   |                                       |   |  |  |            |             | 28f. Location /5                 | Street and No                   | ımber or R                            | lural Route Number                                |  |  |  |
| To Be                | 3 🗌 Suicide  | 3 Suicide 4 Homicide  286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  287. Location (Street and Number or No. 1)  City or Town, State) |            |   |                                       |   |  |  |            |             |                                  |                                 |                                       |   |  |  |  |
| To Be                | 3 🗌 Suicide  |  |            |   |                                       |   |  |  |            |             |                                  |                                 |                                       |   |  |  |  |
| Certification: To Be | 3 Suicide<br>4 Homicide  |  | ing Dh     | 29a. Certifler (Check only one)  1 Certifling Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  FARHAD SAMALI MD. 7305 Hansver Pkwy Greenfelt MD 20770  31. Date filed (Month, Day, Year)  AUG 1 5 2007  AUG 1 5 2007 |                                       |   |  |  |            |             |                                  |                                 |                                       |   |  |  |  |
| Certification: To Be | 3 Suicide 4 Homicide  29a. Certifier (Check only)  | 1 Certifyi   |            | er: On the b  | asis of examir                        | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the and manner stated. |  |  |            |             |                                  |                                 |                                       |   |  |  |  |
| Certification: To Be | 3 Suicide 4 Homicide 29a. Certifier (Check only one)   | 1 ☐ Certifyi<br>2 ☐ Medica   | l Examin   | er: On the band man   | asis of examir<br>ner stated.         | ation and   |  | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo |            |             |                                  |                                 |                                       |   |  |  |  |
| To Be                | 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature an   | 1 Certifyi 2 Medica  | il Examin  | er: On the band mani  | asis of examin                        | and and   | ·  | 29c. Licens  | se number  | -0:         | 2/2                              | 29d. Date sig                   | gned (Mon                             | ith, Day, Year)                                   |  |  |  |
| Certification: To Be | 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature an   | 1 ☐ Certifyi<br>2 ☐ Medica   | il Examin  | and man   | asis of examirater stated.            | ent.  | )  | 29c. Licens  | se number  | 82          | 2/3                              | 29d. Date sig                   | gned (Mon                             | th, Day, Year)                                    |  |  |  |
| Certification: To Be | 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature an   | 1 Certifyi 2 Medica d title of certific  | ier        | ner: On the band mann   | asis of examir<br>her stated.         | em 23a) (   | Type, Pri  | 29c. Licens  | o o S      | 82          | 2/3                              | 8/5                             | gned (Mon                             | th, Day, Year)                                    |  |  |  |
| Certification: To Be | 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature an   | 1 Certifyi 2 Medica d title of certific  | ier        | mpleted caus  | asis of examirate stated.             | 730   | Type, Pri  | 29c. Licens DC   | o o s      | -82<br>Kny  | Green                            | 8/5                             | ined (Mon                             | ith, Day, Year) 007                               |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

|          |                            |  |                           | 1 - For<br>State<br>Registrar Amend 23a, perl  | State of Maryland 15/01  |   |  |   |   | ene g. No.                       | 07                       | 26144  |  |
|----------|----------------------------|--|---------------------------|--|--|---|--|---|---|----------------------------------|--------------------------|--|--|
|          |                            | Physici<br>/Medi   |                           | 1. Decedent's Name (First, Middle, Last  |  |   |  |   | 2. Date of Death<br>Month   | FDay 20                          | Year<br>7                | 3. Time of Death 3:35A M                           |  |
| 157      |                            | Examir   |                           | 4a. Facility Name (If not institution, give Atlantic General   | street and number)<br>1 Ho Sp1 ta  | 1   | 4b. City, Town,<br>Berl                                    | or Location of Deat                                   |   | 4c. County of Death Worcester    |                          |  |  |
| 3/1929   | _                          | Funeral<br>Director  |                           | 5. Social Security Number 220-24-4899  1 M 2 F 78  7. Age (In yrs. last birthday) Yrs.  7. Age (In yrs. last birthday) Yrs.  1 Under 1 Year If Under 24 Hrs. Months Days Hours Min.  (Month, Day, Year) July 23.1929 |  |   |  |   |   |                                  |                          | 9. Birthplace (State or Foreign Country) Maryland  |  |
|          | 0/2                        | deeth with the Maryland<br>ms 23a or 28a-f show  | tor                       | 10a. State 10b. County Maryland Worcest  |  | City, Town or L   | ocation<br>in City   |   |   |                                  | 1                        | 0d. Inside City Limits 1 X Yes 2 □ No              |  |
| !        | 8/9                        | or 28a   | Funeral Director          | 10e. Street and Number   |  |   | 10f. Zip Code  |   | 10  | g. Citizen of V                  | Vhal Cour                | ntry?  |  |
| DOB      | Öd                         | s 23a  | ral                       | 617 Gulf Stream D  |  |   | 218  |   | U.S   |                                  |                          |  |  |
| Ŏ        | 8                          | s 1 end 2 should be filed within 72 hours after deeth with the Maryla if Health and Mental Hygiene. Item 27 is marked other than "nature!", or items 23e or 28e1 show other traumatic event, the Medical Examiner, ust be notified at                          | by                        | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☎ Widowed 4 □ Divorced  | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:            | 10.5.   | Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ N           | Hispanic Origin? (Suban, Mexican, Puerlo<br>Specify:  | pecify Yes or No-<br>lo Rican, etc.)  |                                  | k, White,                |  |  |
| 30       | 21215-0036                 | within 72 ho<br>ene.<br>than "natur<br>he Medical  | Completed                 | 15. Decedent's Edu<br>(Specify only highest grad<br>Elementary/Secondary (0-12)  | completed) College (1-4or 5+)  | (Give   | dent's Usual Occ<br>e kind of work don<br>DO NOT use retii | rking   | 16b. Kind of Business/Industry  Grocery Store                                   |                                  |                          |  |  |
| 1801     | 9                          | filed v<br>Hygie<br>other t  |                           | 12<br>17. Father's Name (First, Middle, Last)  | 0  | Sa  | les Cler   |   | ne (First, Middle, M  |                                  |                          | 716  |  |
| 4.       | /lan                       | 2 should be filed within<br>and Mental Hygiene.<br>Is marked other than<br>aumatic event, the Ma   | To Be                     | Adam Hasp  | ert  |   |  | Magdali   | na L  | ang                              | •                        |  |  |
| 24       | , Maryland                 | 1 end 2 should:<br>Health and Men<br>iem 27 le marke<br>other traumatic  |                           | 19a. Informant's Name/Relationship (7) Catherine M. Antho  | ny (Daughter   | ) 1408  | Theis Dr   | et and Number or Ru<br>ive, Pasa                      |   |                                  |                          | •  |  |
| 0        | altimore,                  | it of Harring It It Item   |                           | 20a. Method of Disposition 1   | lamoval from State   | <ul> <li>Place of Disposition</li> <li>cemetery, cre</li> </ul> | osition (Name of<br>matory or other p                      | lace)   | Date 2  | Oc. Location -                   | City or To               | own, State   |  |
| 320      | Itin                       | permit. Pages<br>Department of b<br>Important: If ite<br>any Injury or of  |                           | 4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens   |  |   |  | Cem. 08-  |   |                                  |                          | Maryland   |  |
| 6, 0     | B                          |  |                           | Jan 1  | Houns  | $M_3$   | cCully-P<br>204 Moun                                       | <sup>ress of Facility</sup><br>olyniak F<br>tain Road | uneral Ho   | me P.A.                          | vland                    | 21122  |  |
| 4        |                            | Physician //Medical Examiner burial-transit sthe purial-transit  |                           | 23a. Part1. Enter the disease, or compleshock, or heart failure. List only of mmediate Cause (Final disease or condition   | ications that caused the die cause on each line.   | eath. Do not en<br>etastatic                                    | ter the mode of d  | ring, such as cardia                                  | or respiratory arre   | st,                              |                          | Approximate<br>Interval Between<br>Onset and Death |  |
|          |                            |  |                           | resulting in death)  a. Due to (or as a consequence of):  Oringers   |  |   |  |   |   |                                  |                          |  |  |
| e)       |                            |  | er                        | Sequentially list conditions, if any, leading to immediate   | Due to (or as a cons   | sequence of):   |  | U   |   |                                  |                          |  |  |
| Marie    |                            |  | Examiner                  | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | s  |   |  |   |   |                                  |                          |  |  |
| 3        | 8760,                      | be exe<br>icien a<br>burial-   | a Ex                      | resulting in death) Last Due to (or as a consequence of):  |  |   |  |   |   |                                  |                          |  |  |
| -        | 687                        | flicate be<br>g physicie<br>as the buri  | edical                    |  | 1.   |   |  |   |   |                                  |                          |  |  |
| ter land | P.O. Box (                 | Hospital or Attending Physician: The law requires that the death certific 24 hours after death. Funeral Director: After this certificate has been signed by the attending Is therefore the force at the funeral director, page 2 should be detached for use as | Completed by Physiclan/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/flhs? 1 □ Yes 2 ☑ No 9 □ Unknown   | 3c. If yes, outcome of pre<br>1 □ Live birth 2 □ F<br>4 □ Pregnant at time of<br>9 □ Unknown | etal death 3[   | □Ectopic pregnan<br>□ Other (specify)                      | су  |   | 23d. Date<br>Mor                 | e of delive              | ory<br>Day Year                                    |  |
| I        |                            | w requires that the stand by should be detact  |                           | Part II. Other significant conditions con  | ntributing Io death but nol  | resulling in the u  | ınderlying cause ç   | iven in Part I.                                       |   |                                  | ibute to th              | ge cause of death?                                 |  |
|          | 000                        | aw rec<br>is beer<br>2 shou  | plete                     |  |  |   |  |   | 24a. Was an   | 24b. V                           | Vere auto                | psy findings available                             |  |
|          | A.                         | The lavate has   | Com                       |  |  |   |  |   | autopsy<br>perform<br>1 Yes 2   | ed?                              | rior to cor<br>leath?    | mpletion of cause of                               |  |
|          | Vita                       | ysician: The l<br>is certificate ha<br>director, page  | Be                        | 25. Was case referred to medical examiner?   | lospital:  |   |  |   | ath Check only one  | 1                                |                          |  |  |
|          | o                          | Phys<br>r this<br>ral dir  | ٠ <u>.</u> ٢٥             | 1 Yes 2 No   | 1 Inpatient 2  | 28b. Time o   |  |   | lome 5 Resider  |                                  |                          | y)   |  |
|          | ion                        | nding<br>ath.<br>r: Afte<br>e fune   | atlon                     | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation   | 28a. Date of Injury<br>(Month, Day Year  | ) Injury  | W  | ork?<br>□Yes 2□No                                     | 250. 5030/150 /160  | w injury occurs                  | <b>.</b>                 |  |  |
|          | Division of Vital Records, | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral   | Certification:            | 3 Suicide 6 Could not be determined  | 28e. Place of Injury - A building, etc. (Spe   | t home, farm, st<br>ecify)                                      | reet, factory, office                                      | Э   | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                                  |                          |  |  |
|          |                            | Hospi<br>24 hour<br>Funer<br>itely fill  | Medical                   | 29a. Certifier 1 Certifying Physical Check only one)   | sician: To the best of my  | knowledge, deat<br>ination and/or in                            | h occurred at the<br>evestigation, in my                   | time, date and place<br>opinion, death occu           | , and due to the ca<br>irred at the time, da                                    | use(s) and ma<br>te and place, a | nner as st<br>and due to | tated. the cause(s)                                |  |
|          | _                          | To the within 2 To the complet   | Mec                       | 29b. Signature and title of certifier  | and manner stated.   |   |  | nse number  | 29  | d. Date signed                   | (Month,                  | Dey, Year)   |  |
|          |                            | 7  |                           | Kustine &  | uggin, M   | D   | C1-0   | 000795  |   | 8-8-2                            | 007                      |  |  |
|          | 1                          | 6  |                           | 30. Name and address of person who co<br>33195 Lighthouse<br>31. Date filed (Month, Day, Year)   | empleted cause of death (I   | tem 23a) (Type,   | Print) K   | stine 6   | crithn,   | MO                               |                          |  |  |
|          | (                          | Sta  | to                        | 31. Date filed (Month, Day, Year)  | ROAA, Sujfe  | gnature /   | elbyvili   | ie, ise 10  | 1975  |                                  |                          |  |  |
|          |                            | Registr  |                           | AUG 1  | 2007 Llean   | 1 /s  | HOBEL  | 7   |   |                                  |                          |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 415A M borah Har 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSP Ita toni timore Ka Northwe If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year, 01/25/1939 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2**)** F 217-36-9494 68 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ", or items 23a or 2 caminer must be n Funeral 3420 ASSOCIATED WAY #320 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. by Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any injury or other traumatic event, the Medical ones. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 CLERK FOREIGN SERVICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LOUIS HARRIS **BERTHA MEYERS** ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRAN COHEN / SISTER 9136 RUTH ELDER LANE - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State SHAAREI ZION CONG. 08/14/2007 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licensee INC. Matt Cen 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician mont /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to innuculat cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be irector, page 2 s autopsy performed? Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one rthis c Hospital: Other: PL No Certification: To 1 Tyes 1 ☑ Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After that in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide n 24 hours aff le Funeral Di letely filled ir TSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

Medical completely within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ICIUST MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) )essa MD Ed Northwe 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2007 DHMH 17 Rev 1/2001 **ORIGINAL** 

Certificate of Death

Reg. No.

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4031 AM inerva 20 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 2516 MCCULLOH ST BALTIMORE 6. Sex if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours 1 M 2 TF 7, 1919 88 MARYLAND July 220-03-9802 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 1√ Yes 2 No Examiner must be notified BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'natural", or items 23a 2516 MCCULLOH ST 21217 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status a filed within 72 hours after dual Hygiene. Black, White, etc. 1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: 3 X Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC DOMESTIC and Mental Hygie Is marked other permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If item 27 is marked any injury or con-18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ JOHN F. BURGESS CATHERINE SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EVERETT B. JOHNSON/SON 2516 MCCULLOH ST. BALTIMORE, MD 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 IC Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8/15/2007 METRO CREMATORY BALTIMORE, MARYLAND 21. Signature of Funeral Service Licen 22. Name and Address of Facility
WILLIAM C. BROWN COMMUNITY FUNERAL HOME P.A. 1206 W. NORTH AVE. BALTIMORE, MD 21217 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, to cause on each me. Approximate Interval Between Onset and Death rt1. Enter the disease, or com shock, or heart failure. List only mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ 1 Tes 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1□ Yes 20 No to the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 2 28a. Date of Injury (Month, Day Year) funeral 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural Injury 1 Tyes 2 No 2 ☐ Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onl. 296. Signarure and title of certifie 9c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 33rd St #136 BAGT. M 200 Ando 31. Date filed (Month, Day 32 Begistrar's Signature State Registrar

RIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 12:25 PM LIAN 07 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner RALTIMORE HOSPITAL SAMA RITAN G-00A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 216-09-8204 1 □ M **%** □ F 86 MD 1, Director Oct. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1X Yes 2 □ No Director N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or 21206 4220 Diller Avenue "natural", or items 23a U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) than 7 is marked other tha traumatic event, the Own Home <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ages 1 and 2 should be file ont of Health and Mental Hit: If item 27 is marked oth y or other traumatic eveni Be Lula Dietzway ပ Henry Lutz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5511 Plymouth Road, Baltimore, Md. Christopher Jones/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If i any injury or once. Moreland Mem'l Park 8/13/2007 Baltimore, Md. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home, Inc. 9705 Belair Road, Nottingham, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician lassive disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed 510 as the burial-tran Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical attending p IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 🗌 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 □ Yes certificate 1∐ Yes 2 No Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 40 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending ospital c.
4 hours after dea.
7.meral Director: After 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the .. within 24 hourder To the Funeral D' 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

Year)

AUG

GOOD 32. Registrar's Signature 29c. License number

29d. Date signed (Month, Day, Year)

5601 LOCH RAVEN Blud.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 1 per dyr 9870 8-15-07 vt
State of Maryland 7 Department of Health and Mental Hygiene 1- State Amend #11, perFD, g870, 8/21/07 TT Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month 12<sub>,</sub> Edward J. Jasinski 2007 August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 956 Seneca PArk Road Middle River Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2 □ F 219-03-0784 88 Aug.8,1919 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits ner must be notified at Baltimore Director MD MIddle River 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 956 Seneca Park Road 21220 USA Funeral Pages 1 and 2 should be filed within 72 hours after deathnent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify: þ Specify: White -9. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Machinist the US Government 12th tem 27 is marked other other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Jasinski ပ Mary Popiacki 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gil Jasinski / son 4029 Bay Drive Baltimore MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of I
Important: If ite
any injury or or
once, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State St.Stanislaus 8/16/07 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signator of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD aluel Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician JIRS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician an s the burial-tr Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as ed by the attending detached for use as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 T I Inknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Cordio myopothy, Aortic stemsis 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Dizbejes mellites 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To nours after death.

neral Director: After this
filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) P-22. who completed cause of death (Item 23a) (Type, Print) Fullerton Ave Balto, MD21236 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

5

AUG 1

| 07-06170 .  | •                      | Please Type  | or Print in Black Inc  | lelible Ink. E   | insure All Copi  | es Are Legib  | ole.   |  |
|---|------------------------|--|--|--|--|---|--|--|
| Dorothy E. Johns  |                        | 1- For State<br>Registrar  |  | tment of Hea<br>ificate of Dea                             |  | lygiene<br>Reg. N                                     |  | 7 2511   |
| Physicia<br>Medical Exami   | ın/                    | Decedent's Name (First, Middle,La  | Shnew  | -  | a a  | 2. Date of Death<br>Month Da<br>August 11, 20         | y Year<br>007  | 3. Time of Death<br>0840 hrs                       |
|   |                        | 4a. Facility Name (if not institution, g<br>3700 Greenspring Ave   | ve street and number)  |  | Town, or Location of Deat<br>more                                | h   | 4c. County of Death  |  |
| Funeral<br>Director   |                        | 5. Social Security Number 6. S<br>213. 78. 4163  | Sex 7. Age (In yrs. las  | t birthday) If Und<br>Mont                                 | der 1 Year   If Under 24Hr<br>hs   Days   Hours   Min            |   | Foreig   | hplace (State or<br>n<br>untry)                    |
| Maryland<br>28a-f show any<br>d at once,  | rector                 | Usual Residence of Decedent 10a. State 10b. County 10e. Street and Number  | 10c. City, T   | own or Location  Bautimor 10f. Zi                          | €<br>p Code  | 10g.  | Citizen of What Cour   | 10d. Inside City Limits 1 Yes 2 No                 |
| after death with the Maryland al", or items 23a or 28a-f sho ner must be notified at once   | by Funeral Director    | 3700 Green Spr 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce   | 12 Was Decedent Ever in U.S  |  | Plant of Hispanic Origin? (Sifty Cuban, Mexican, Puert           | specify Yes or No-                                    | 14. Race - Ameri<br>White, etc.  | can Indian, Black,                                 |
| 11215-0036 Id be filed within 72 hours at dental Hygiene. narked other than "natural event, the Medical Examin  | Completed b            | 15. Decedent's Education (Specify Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Las   | College (1-4 or 5+)  | during most of wo  | I Decupation (Give kind of orking life, DO NOT use re            |   | Domestic   |  |
| Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shinjury or other traumatic event, the Medical Examiner must be notified at once | To Be C                | 19a. Informant's Name/Relationship  Condido Condido  20a. Method of Disposition  Burial 2 Cremation 3  Donation 5 Other Special  21. Signature of Funeral Service Lice | Type, Print)  Sch Daughte  20b. Pl.  Removal from State  CT                                    | BLOBiace of Disposition (National Property of Other place) | Della s (Street and Number or  Combic Lin H  ame of cemetery, a) | Johnson Rural, Route Number Pt 101 Pra Date 20 20:207 | City or Town, State  and all sta  Oc. Location - City or  Baltims  Rene (une | n mD 21133 Town, State  re, mD  rel Server         |
| Physician<br>/Medical<br>xaminer  |                        | 23a. Part in Enter the disease, or confailure. List only one cause on Immediate Cause (Final disease or condition resulting in death)                                  |  | is   | of dying, such as cardiác  |   | shock, or heart  | Approximate Interval<br>Between Onset and<br>Death |
| ed<br>nsit  | Examiner               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last             | Due to (or as a consequence of):  Due to (or as a consequence of):                             |  |  |   |  |  |
| Box 68760, to death certificate be execut the attending physician and red for use as the burial - trait   | Physician/Medical      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknow   | AMENDED 7, perME, 887  23c. If yes, outcome of pregnat 1 Live birth 4 Pregnant at time of deal | ancy<br>2 Fetal death                                      | 3 Ectopic pregr  |   | 23d. Date of delivery  Month E   | Day Year   |
| tal Records, P.O. cian: The law requires that th certificate has been signed by ector, page 2 should be detach  | Completed by P         | Part II. Other significant conditions  | contributing to death but not res  | ulting in the underlyin                                    | g cause given in Part I.   | 1 Yes 2 24a. Was an autopsy performe                  | 24b. Were au   | topsy findings available completion of cause of    |
| IVISION Of VI<br>or Attending Physi<br>after death.<br>Director: After this<br>I in by the funeral dir  | Certification; To Be C | 25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death 1 X Natural 5 Pending Investiga 2 Accident Investiga 3 Suicide 6 Could no                | 28a. Date of Injury (Month, Day,Year)  tion t be   | 28b. Time of Injury  | 28c. Injury at Work?   | ing Home 5 Res  | injury occurred  |  |
| Di<br>To the Hospital<br>within 24 hours a<br>To the Funeral I  | Medical Cert           | 4 Homicide determin 29a. Certifier 1 Certifying Physi  |  | d/or investigation, in m                                   |  | d due to the cause(s) at the time, date and           | and manner as state  | e cause(s)   |

State 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

Registrar

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

Margarita Korell MD.

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 12, 2007

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                |  |                | 1 - For Amend It   | State of lem 25 per   | Maryland /<br>dr.g870                              | Depa<br><b>,08</b> /    | irtment<br>15/07<br>tincate                          | of He               | ealth a<br>Death                    | and Me                    | ental H                       | ygien<br>Reg. N          | e2 0 1                    | )7               | 26150  |
|--------------------------------|--|----------------|--|---|--|-------------------------|--|---------------------|-------------------------------------|---------------------------|-------------------------------|--------------------------|---------------------------|------------------|--|
|                                | Discontinu   |                | Decedent's Name (First, Middle, L  | .ast)   |  |                         |  |                     |                                     | :                         | 2. Date of D                  |                          |                           | Vana             | 3. Time of Death   |
| ı                              | Physic<br>/Medi  |                | Anna May Johns   |   |  |                         |  |                     |                                     |                           |                               | 26, 2                    | 2007                      | Year             | 6:15PM M   |
|                                | Examir   |                | 4a. Facility Name (If not institution, g   |   | er)  |                         | 4b. City, To   | own, or l           | ocation o                           | of Death                  |                               | 40                       | . County o                | of Death         | 1  |
|                                |  |                | 6409 Continenta  |   | A (1 t 4   |                         |  |                     | urnie                               |                           |                               |                          | Anne .                    |                  |  |
|                                | Funeral<br>Director  |                | 217-46-3058  | Sex 7.<br>1 M 2 ▼ F   | Age (In yrs. last                                  | Yrs.                    | If Under 1<br>Months                                 | Days                | Hours                               | Min.                      | B. Date of B. (Month, Deb. 17 | av. Year                 | ).                        | Col              | place (State or Foreign<br>intry)<br>land                |
|                                | and w  |                | Usual Residence of Decedent 10a. State 10b. County   |   | 10c. City, To                                      | own or Lo               | cation   |                     |                                     |                           |                               |                          |                           |                  | 10d. Inside City Limits                                  |
|                                | Mary<br>-1 sh  | ō              | MD Anne A  | runde1  | G  | 1en                     | Burnie   |                     |                                     |                           |                               |                          |                           |                  | 1 ☐ Yes 2 ☑ No   |
|                                | r 28a  | Director       | 10e. Street and Number   |   |  |                         | 10f. Zip C   |                     |                                     |                           |                               | 10g. C                   | itizen of W               | hat Cou          | intry?   |
|                                | th witi  | a D            | 6409 Continental   | Drive   |  |                         |  |                     | 210                                 | 061                       |                               |                          | U                         | SA               |  |
| 980                            | within 72 hours atter death with the Maryland ane. then "natural; or items 23s or 28s-1 show the Medical Esaminer must be notified at                            | by Funeral     | 11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  | 12. Was Decede<br>Armed Force<br>1  Yes 2<br>If Yes, Give<br>Year or Date | es?<br>∭No   | 1                       | Vas Decede<br>f Yes, specif                          |                     | panic Orig<br>, Mexican<br>Specify: | gin? (Spec<br>i, Puerto R | ify Yes or Nican, etc.)       | 10-                      |                           | , White          |  |
| Baltimore, Maryland 21215-0036 |  | Completed      | 15. Decedent's<br>(Specify only highest g<br>Elementary/Secondary (0-12)<br>1 2  | Education<br>trade completed)  College (1-4)                              |  | (Give<br>life. l        | lent's Usual<br>kind of work<br>DO NOT use<br>cretai | done du<br>retired) | ion<br>uring most                   | t of working              | 7                             | 16b. F                   | Kind of Bus               | siness/li        | ndustry unk  |
| d                              | <b>3 £ € €</b>   | Be C           | 17. Father's Name (First, Middle, Las  |   |  |                         | 010001   | -                   | 18. Mothe                           | r's Name (                | First, Middl                  | e, Maidei                | n Sumame                  | )                |  |
| lan                            | 9 00 - 3   | ToB            | Marion Sebree  | Lewis   |  |                         |  |                     | Bes                                 | ssie l                    | May He                        | ender                    | cson                      |                  |  |
| ary                            | should have  | _              | 19a. Informant's Name/Relationship   | (Type, Print)   | 1:   | 9b. Mailir              | g Address (  | Street an           | nd Numbe                            | r or Rural                | Route Num                     | ber, City                | or Town, S                | State, Zi        | p Code)  |
| Σ,                             | is t and 2 should E<br>of Heaith and Ment<br>itsm 27 is marked<br>other traumatics   |                | Jerry Johns/spo  | use   |  |                         | Conti  |                     | tal D                               | )rive                     | Glen                          | Burn                     | ie, N                     | 1D               | 21061  |
| imore                          | permit. Pages t<br>Department of H<br>Important: if its<br>any njury or oth<br>once.   |                | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  4 ☒ Donation 5 ☐ Other (Spec   | city)   | ite ceme   | of Dispo<br>tery, cren  | sition (Name<br>natory or oth                        | of<br>er place)     | ,                                   | Da                        | te                            | 20c. L                   | ocation · C               | City or T        | own, State   |
| Balt                           | permit. Departimporti  |                | 21. Signature 1 Fun<br>Ronald Sc   | Wade Di   | ector  |                         | Name and<br>ate Ai                                   |                     |                                     | oard<br>21201             | 655 W                         | . Bai                    | ltimo                     | re S             | Street   |
| ł                              | Physician<br>/Medical<br>Examiner  |                | 23a. Part Enter the disease, or co<br>shock, or heart failure. List onl<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)           | a. Cervi  Due to (or  | sed the death. Don line.  Cal Cal as a consequence | NCE<br>e of):           | r  |                     |                                     |                           |                               | arrest,                  |                           |                  | Approximate Interval Between Onset and Death 21/2 movels |
| 8760,                          | death certificate be executed e ettending physicien and ind for use as the burial-transit  | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | to (or  | as a consequenc                                    | e of):                  |  |                     |                                     |                           |                               |                          |                           |                  |  |
| .O. Box 6                      | the death certifi<br>y the ettending<br>ched for use as  | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown  |   | 2 Fetal dea<br>t at time of death                  |                         | Ectopic preg<br>Other (spec                          |                     |                                     |                           |                               |                          | 23d. Date<br>Mont         |                  | ery<br>Day Year  |
| rds, P.                        | w requires that<br>been signed by<br>should be deta  | þ              | Part II. Other significant conditions  | contributing to death   | h but not resulting                                | in the ur               | iderlying cau  | se given            | in Part I.                          |                           |                               |                          | . /                       |                  | he cause of death?                                       |
| Division of Vital Records,     | The law<br>ate has b<br>page 2 s   | e Completed    | 25. Was case referred to medical   |   |  |                         |  |                     |                                     |                           | 1 ☐ Yes                       | ormed?                   | pri                       | or to co<br>ath? | opsy findings available impletion of cause of            |
| 5                              | Physicism:<br>this certific<br>ral director,   | <b>6</b>       | examiner?  | Hospital:   | atient 2 ER/0                                      | Jutantian               | 3 □ DOA  | Other               |                                     |                           | Check only                    |                          | a Cloub                   |                  | 4.1  |
| ion of                         | Attanding Phy<br>ir death.<br>ector: After this<br>by the funeral c  | ation: To      | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigate  | 28a. Date of li<br>(Month, I  |  | . Time of<br>Injury     |  | Injury a Work?      | 4 🗆 1401                            |                           | d. Describe                   |                          | 6 Other                   |                  | (y)  |
| Divis                          | al or Atta<br>s after dea<br>si Directo<br>ad in by th   | Certification: | 3 Suicide 6 Could not<br>4 Homicide determined   | 28e. Place of   | Injury - At home,<br>etc. (Specify)                | farm, stre              | eet, factory, o                                      | ffice               |                                     | 28                        | f. Location<br>City or To     | (Street ar<br>own, State | nd Number<br>9)           | r or Rur         | al Route Number,   |
|                                | To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, | edical (       | 29a. Certifier 17 Certifying P (Check only one) 2 Medical Exa  | hysician: To the be<br>miner: On the basis<br>and manner                  | s of examination a                                 | ge, death<br>and/or inv | occurred at<br>estigation, in                        | the time<br>my opir | , date and<br>nion, deat            | d place, an<br>h occurred | d due to the<br>at the time   | cause(s<br>, dale an     | ) and mani<br>d place, ar | ner as s         | stated.<br>o the cause(s)                                |
|                                | withii To tl   | Σ              | 29b. Signature and title of certifier  |   |  |                         | 29c. l   | icense r            | number                              |                           |                               | 29d. Da                  | le signed                 | (Month,          | Day, Year)   |
| 7                              |  |                | Manh   | our   | ( · D  |                         |  | D3                  | 95                                  | 20                        |                               | 140                      | gus                       | t 2              | -, 200 t   |
|                                |  |                | 30. Name and address of person who   | arkan   | f death (Item 23a                                  | (Type, I                | oital  | 180                 | Gle                                 | en B                      | ·~~                           | se,                      | MD                        | . 2              |  |
|                                | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)<br>AUG 1 5 2007  | 32. Regi  | strar's Signature                                  | ost                     | ,  |                     |                                     |                           |                               |                          |                           |                  |  |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 3:28 PM Julia Johnson 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A **Baltimore** AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 ☐ F Director So.Carolina 213-20-3028 86 Aug 18, 1920 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show must be notified at 1 X Yes 2 No Director Baltimore N/A Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò 1223 Harwall Road 21207 U.S.A. 23a Funeral death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or Items 11. Marital Status Examiner Black, White, etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify. ģ Black 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 lopparment of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other trained. the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Pettigrew David Pettigrew မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1223 Harwall Road Baltimore, Maryland 21207 Barbara Mitchell Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 TXBurial 2 □ Cremation 3 □Removal from State 08/17/07 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) Western Cemetery 21. Signature of Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part. Enter he disease, or complications that caused the drath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line.

Immediate Caus (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner CARDIO RE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit 0581BLE Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ş 1 Yes 2 No 3 Probably 4 ☐Unknown HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has page 2 perform certificate 1□ Yes HYPER 2 M No Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**№** No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ After this Division or . Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Attending 5 ☐ Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide or / within 24 hours a

To the Funeral C Medical 29a. Certifier Macertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) M.D AUG, 11, 2007 20556. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 900 LOVET ISBETH 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

HOL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene/ 1 - State Registrar Amend #26, perMD, g870, 8/15/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8 Month **Physician** 20Ŏ**7**°' 4:20a. Rita M. Jeffers /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown 9400 Painted Tree Drive If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 → F 8-13-1952 ear) 212-60-5726 54 Director MD Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show must be notified at MD Catonsville Baltimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 116 Cherrydell Avenue, Apt. 2 21228 USA 23a death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or iter any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Never Married 2 Married 1 Tes 2 If Yes, Give Year or Dates: African-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Thomas G. Hayes Elem. School Elem. School Principal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laura Mae Bulluck Zachary Jeffers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9400 Painted Tree Drive, Randallstown, MD 21133 Zachary C. Jeffers/Brother 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Buria 2 □ Cremation 3 □ Removal from State 4 □ Denation 5 □ Other (Specify) 8-13-07 Arbutus Mem. Park Arbutus, MD 21. Sanature of Funeral Service Licenses 22. Name and Address of Facility Wylie F/H P.A. of Baltimore County 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TASTATIC BREAST CANCER **Physician** YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any the ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Exami Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical as attending | for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PENTENSION 2**X**No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has er this certificate has eral director, page 2 autopsy perforn funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Brother's Residence 2 No Other: 4 \sum Nursing Home 1 ☐ Yes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

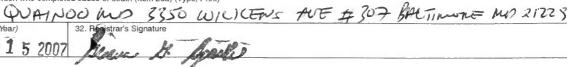
To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and litle of certifier 29d. Date signed (Month, Day, Year)

State Registrar

AUG 15

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



00061765

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 31 per dyr. 870 8-15-07 vt.

State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** Edward Winters Krahe August 10,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Parkton
Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) 18450 Pretty Boy Dam Road Baltimore Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav) **Funeral** Months **™** 2□ F Yrs. Director 579.44.5732 79 May 7,1928 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 1 Yes No Director Shrewsbury PAYork 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 704 Bollinger Drive 17361 Funeral S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 17€Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Kovea Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cartographer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alice E. Shoup John Benjamin Krahe ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Krahe/Wife 704 Bollinger Dr. Shrewsbury, PA 17361 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If its any Injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crem. 08.11.07 Beltsville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation And Funeral Balto 21. Signature of Funeral Service Licensee <u> Alternatives 8717 Green Pasture</u>s Dr. MD 23a. Part1. Effet the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LASMA ELL /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any setting control cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 4☐Pregnant at time of death 9☐Unknown in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has t irector, page 2 s 1∐ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 1 Yes 2 No Certification: To 6 Bother (Specify) hovel After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury after death.

Director: At 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funeral critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discription of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 30. Name and address erson who completed cause of death (Item 23a) (Type, Print) Battimore MD GORGUN EK 32. Registrar's Signature

AUG 1 5 31. Date filed (Month, Day, Year) State 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 5:40 AM Camala /Medical 4a. Facility Name (If not institution, give street and number) 4c County of Death 4b. City, Town, or Location of Death Examiner MINDSOY MIL If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 □ F 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Months Days Hours Min. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 WNo Directo Windscr 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Court Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 ANo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No Specify: 9 Specify: 3 Nividowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 010 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nadetti 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State aughn C 21. Signature of Funeral Service Licensee 22. Name and Address of Facility . Great funeral Approximate Interval Between as and Death 23a. Part1. Enter the disease, or complications that caused the feath. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Ather significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ta 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy perform 1∐ Yes completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Hospital: Other: 4 \sum Nursing Home မ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 5 Pending

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: after death.

Director: After this

| 2 Accident                  | investigation                |  | M                           | 1 L Yes 2 L No  |   |   |
|-----------------------------|------------------------------|--|-----------------------------|---|---|---|
| 3 ☐ Suicide<br>4 ☐ Homicide | 6 Could not be<br>determined | 28e. Place of injury - At he building, etc. (Special       | ome, farm, street, factory) | ory, office   | 28f. Location (Street and<br>City or Town, State) | Number or Rural Route Number,                           |
|                             |                              |  |                             | ed at the time, date and place<br>on, in my opinion, death occu |   | and manner as stated. place, and due to the cause(s)    |
| 29b. Signature and ti       | ss of person who con         | opted cause of death (Iter<br>32. Registrar's Signa<br>007 | m 23a) (Type, Print)        | 9c. License number  0054  UVEVELE                               | 29d. Date 0                                       | e signed (Month, Day, Year)  8-13-200  DATMONEMD  21215 |
|                             |                              |  | ODICINIA                    |   |   |   |

Medical

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4c. County of Death Facility Name (If not institution, give street and numb ocation of Death Examiner Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Months Days Hours 1**M** M 2□ F 220-42-6322 64 21,1943 April Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Maryland N/A Baltimore 1 Nes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1744 Jackson Street 21230 U.S.A. Funeral . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2 No ģ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 0 Laborer <u>City of Baltimore</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John King 2 Louise Riddles 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine C. King (Wife) 1744 Jackson Street, Baltimore, Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory 08-14-07 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
130 E. Fort Avenue, Baltimore, Maryland 21230 21. Signature of Funeral Service Licenses rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one susse on each line. Approximate Interval Between Onset and Death mediate Cause (Final isease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that in its days of the cause). Examiner that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown . Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ To 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 000 1 patient 3□ DOA 2 1 ☐ Yes 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No a☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760 signed by the a peen al or Attending Fatter death. within 24 hours after death To the Funeral Director: Hospital

**Funeral** 

Director

If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or ite

permit. Pages 1 and 2 should be Department of Health and Mental Important; If item 27 is marker any injury common

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

with the Maryland

State Registrar

29a. Certifier (Check only

29b. Signature and title of certifie

31. Date filed (Month, Day,

5

DHMH 17 Rev 1/2001

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

07-06049

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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| Sec. 18 | 100 | -3  | ě. | 1100 | 10.5 | 4   | -   |
|         |     |     |    |      |      |     |     |

Satya Duana Long State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle,Last) Physician/ Date of Death 3. Time of Death Month ical Examiner 2233 hrs SATYA Duana August 6, 2007 4a. Facility Name (# not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 18 Cedar Heights Court Apt D Woodlawn **Baltimore County** 5. Social Security Number 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Funeral 7. Age (In vrs. last birthday) If Under 24Hrs. Director Davs Hours 212-90-4682 М Country) 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No with the Maryland Director 10e. Street and Numbe 10g. Citizen of What Country? 2111 Woodt Funeral 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Armed Forces? Yes Widowed If Yes, Give Yea Yes 2 X No specify: Divorced \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 72 College (1-4 or 5+) item 27 is marked other than Baltimore, MD 21215-0036 1 and 2 should be filed within of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be Stephanie Lee 19a. Informant's Name/Relationship (Type, Print) or Rural Route Number, City or Town, State, Zip Code Owings Mills 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State MD tonsville Important: tro Crematory 10,200 Other Specify. 22. Name and Address of Facility

Record A Gray Co.

270 Fred Hel 21. Signature of Funeral Service Licenses 21229 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and Medical Death a. Sharp Force Injuries Immediate Cause (Final disease *x*aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and transit The law requires that the death certificate be executed Physician/Medical tending physician a UNPENDED AMENDED Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Dav Year past 12 months? Pregnant at time of death 1 Yes 2 No 9 V Unknown the 0.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Yes 2 ✔ No 3 Probably 4 Unknown Completed Division of Vital Records, 24a. Was an 24b. Were autopsy findings available certificate has be rector, page 2 sh autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other<sub>4</sub> this ER/Outpatient 3 Inpatient 2 Nursing Home 5 Residence 6 ✔ Other: Scene 2 1 V Yes After th funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: Subject was stabbed and cut Natural FOUND within 24 hours after death.

To the Funeral Director: neral Director: filled in by the f Yes 2 V No Pending Aug 6, 2007 2226 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide or Town, State)
18 Cedar Heights Court Apt D, Woodlawn, MD determined (Specify) Multi-Family Apt. 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and j 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E August 7, 2007 30. Name and addr is f person who completed cause of death (Item 23a) Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Jack Titus Me gistr r's Sign tur State

Registrar

State

John

31. Date filed (Month, Day, Year)

AUG 1 2 COUL

man

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401 W. Belvedere Ave.

Baltlmore

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|              |  |                        | 1- State of Maryla   | •                                       | artment of H  |   | -                                      | giene<br>Reg. No.             | 1117  | 26153   |
|--------------|--|------------------------|--|---|---|---|--|-------------------------------|---|---|
|              | Physic   | ian                    | 1. Decedent's Name (First, Middle, Last)  Marie W. Layton  |   |   |   | 2. Date of De<br>Month<br>08           | ath<br>Day<br>08              | 2007  | 3. Time of Death 10:20 P M                        |
|              | /Med<br>Exami  |                        | 4a. Facility Name (If not institution, give street and number)  Joseph Richey Nursing Home   |   |   | r Location of Death                                 | 00                                     |                               | ty of Death   | 10:20 F W   |
|              | Funeral<br>Director  | T I                    | 216-18-3551 1□M 2점F  | vrs. last birthday)<br>86 Yrs.          | If Under 1 Year<br>Months Days                                  | If Under 24 Hrs.<br>Hours Min.                      | 8. Date of Bir<br>(Month, Da<br>Feb. 7 | th Year)<br>1921              | 9. Birthp<br>Coun                                   | lace (State or Foreign<br>try) MD                 |
|              | the Maryland<br>28a-f show<br>notified at  | tor                    | Usual Residence of Decedent  10a. State  | City, Town or Loc                       |   | timore  |  |                               | 1   | 0d. Inside City Limits 1                          |
|              | h with the<br>3a or 28a<br>st be notif   | Funeral Director       | 10e. Street and Number 1216 N. Longwood Street   |   | 10f. Zip Code   | 21216   |  | 10g. Citizen o                | f What Coun   | try?  |
|              | <b>Baltimore,</b> Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic at a more. | d by Funer             | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ♣ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ♣ No If Yes, Give Year or Dates:  |   | Vas Decedent of H<br>f Yes, specify Cuba<br>I ☐ Yes 2 No        | lispanic Origin? (Span, Mexican, Puerto<br>Specify: | ecify Yes or No<br>Rican, etc.)        | Spec                          | ace - America<br>lack, White,<br>city: Afri<br>Amer | etc.<br>can                                       |
| 3            | Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or any injury or other traumatic event, the Medical Exami any injury or other traumatic event, the Medical Exami once.   | Completed              | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  12   | (Give I                                 | lent's Usual Occup<br>kind of work done o<br>OO NOT use retired | durina most of work                                 | ing<br>unk                             | 16b. Kind of<br>Federa        | Business/Inc  |   |
|              | /land /  | To Be C                | 17. Father's Name (First, Middle, Last) Leonard W. Watkins   | ,                                       |   | 18. Mother's Name                                   | e (First, Middle,<br>zabeth C.         |                               |   |   |
| for          | Mary<br>nd 2 sho<br>lith and<br>27 is ma   |                        | 19a. Informant's Name/Relationship (Type. Print)  Marcel A. Coates / Son   |   |   | and Number or Run<br>e; Baltimore                   |  | -                             |   | Code)   |
| Lay          | nore,<br>ages 1 ar<br>nt of Hea<br>t: if Item 3  |                        | I Bullat 2 Dolemation 3 Diremovaritom State  | b. Place of Dispos<br>cemetery, crem    | sition (Name of<br>natory or other place                        | ce)   | Date                                   | 20c. Location                 | - City or To  |   |
| Marie Layton | Baltin permit. P. Departme Important any injury once.  | ľ                      | 4 □ Donation 5 □ Other (Specify) A  21. Signature of Funeral Service Licensee  | 22                                      |   | 08/17<br>  ss of Facility   Wy:<br>  ilmor Street   | lie Funer                              |                               | P.A.  | 1and<br>21217                                     |
| Σ            | N/4708   |                        | 23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one care, on each line.   |   |   |   |  |                               | y Land  | Approximate Interval Between Onset and Death      |
| •            | Physician<br>/Medical<br>Examiner  |                        | Immediate Cause (Final disease or condition resulting in death)  a. Due to or as a constant of the condition and the condition resulting in death)   | sequent of):                            | umonia  |   |  |                               |   |   |
|              | icate be executed physician and the burial-transit   | dical Examiner         | Sequentially list conditions.  |   | ular dis  | iease   |  | 10.5                          |   | Years   |
| A .          | I KECOrds, P.O. BOX 68/<br>The law requires that the death certificate the has been signed by the attending physoge 2 should be detached for use as the  | by Physician/Medic     | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of  | Fetal death 3□                          | Ectopic pregnancy   | 1   |  |                               | Date of delive                                      | ery<br>Day Year                                   |
| a 4          | dS, F<br>uires that<br>signed b  | l by Pl                | Part II. Other significant conditions contributing to death but not  | resulting in the un                     | nderlying cause giv   | en in Part I.                                       |  |                               |   | e cause of death?                                 |
| 7            | VITAI HECOTGS, slclan: The law requires the certificate has been signe irector, page 2 should be company.  | Completed              |  |   |   |   | 24a. Was<br>auto<br>perfo              |                               | prior to cor<br>death?                              | psy findings available impletion of cause of 2 No |
| 8/0          | VITAI<br>sician: T<br>certificat<br>rector, pa   | Be                     | 25. Was case referred to medical examiner?  Hospital:  |   | Oth.  | 26. Place of Deat                                   | h (Check only o                        | one)                          |   | 11 -  |
|              | n Or<br>ng Phy<br>fter this  | ation: To              | 1 Yes 2 No rospital 1 Inpatient 2  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  | 2 ER/Outpatient 28b. Time of Injury     | 28c. Injur<br>Wor   | 4 LI Nursing Ho                                     | me 5 Resi                              |                               | other (Specify<br>urred                             | 1)HOSPICE   |
|              | DIVISION al or Attending a after death. In Director: After d in by the fune  | Sertifica              | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - A building, etc. (Sp.   | it home, farm, stre<br>ecify)           | eet, factory, office  |   | 28f. Location (;<br>City or To         | Street and Nur<br>wn, State)  | mber or Rura  | l Route Number,                                   |
|              | DIVISIO To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu  | Medical Certification: | 29a. Certifier (Check only one)  1  Certifying Physician: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.  | knowledge, death<br>nination and/or inv | occurred at the tirvestigation, in my c                         | me, date and place,<br>opinion, death occur         | and due to the<br>red at the time,     | cause(s) and<br>date and plac | manner as st<br>e, and due to                       | tated. the cause(s)                               |
|              | To th<br>within  | M                      | 29b. Signature and title of certifier  |   | 29c. Licens   | A   | /5                                     | 29d. Date sign                | 10  |   |
|              | 57   |                        | 30. Name and address of person who completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of death (1)  The Month of the completed cause of the cause of the cause of the completed cause of the cause of the  | Item 23a) (Type, I                      | Print)<br>N. Fut  | D2417   | Itima                                  | re MID                        | 7.17  | 01  |
|              | St<br>Regist   | ate<br>trar            | 30. Name and address of person who completed cause of death (to the state of the st | ignature                                | to the  | ) 1 1/0   |  | -100                          | 2,13  |   |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20c per fh 98/0 8-15-07 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 9:40 9 M LEONA S LURIE 2007 maust 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE
The left Year | If Under 24 Hrs. Hours | Min. KESWICK NURSING HOME Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 😿 F 94 07/18/1913 NY 220-07-4247 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County N/A 1 Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 W. 40TH STREET 21211 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 🕽 No WHITE Specify: Specify: 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) BUSINESS MANAGER MANAGEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERSCHEL KAPLAN LIBBY UNOBTAINABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8531 HILL SPRING DRIVE - LUTHERVILLE, MD 21093 EUGENE SCHWARTZ / SON 20c. Location - City or Town, State

BALTTMORE, MD.

REISTERSTOWN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CONG. 08/14/2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2 weeks Cerebro-vascular acadent with left hear pareses Due to (or as a consequence of). unknower Cerebro - hadeul at disease with dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

Examiner Division or Vital Records, P.O. Box 68760, attending physician To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica

**Physician** 

/Medical

Examiner

Director

Funeral

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Be Completed

10a. State

MD

**Funeral** 

Director

ortant: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event.

**Physician** 

/Medical

Examiner

Physician/Medical

Completed

Be

ို

Certification:

Medical

29b. Signature and title of certifier

V7. Babelle

Baltimore, Maryland 21215-0036

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29c. License number

D13657

29d. Date signed (Month, Day, Year)

august 13,2007

State Registrar

MACGRELIR, 700 W 40 Th STREET, BALTITIARE, 77D 21211 17- ISBELLE 31. Date filed (Month, Day, Year) AUG 15 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

regul MD

| •   |                  | For<br>State<br>Registrar  | State of Ma  | aryland                                 |                             | artmen<br>rtificat                |                    |                                  | d Me       |                                 | ienę<br>eg. No.    | Uul                         | 25160  |
|---|------------------|--|--|---|-----------------------------|-----------------------------------|--------------------|----------------------------------|------------|---------------------------------|--------------------|-----------------------------|--|
|   |                  | 1. Decedent's Name (First, Middle, La.   | st)  |   |                             |                                   |                    |                                  | 2          | . Date of Deat                  |                    | Voor                        | 3. Time of Death                                   |
| Physicia<br>/Medic  |                  | James J. McKi  | nley   |   |                             |                                   |                    |                                  |            | Month<br>08                     | O1                 | 2007                        | 0950 ™   |
| Examin  |                  | 4a. Facility Name (If not institution, give  |  |   |                             | 4b. City,                         | Town, or           | Location of D                    | eath       |                                 | 4c. (              | County of Dea               |  |
|   |                  | Holy Cross Hosp  | ital   |   |                             | Si                                | ilve               | r Sprin                          | ıg         |                                 | Me                 | ontgome                     | ery  |
| Funeral   |                  | <ol><li>Social Security Number 6. S</li></ol>  |  |   | st birthday)                | If Under<br>Months                | 1 Year<br>Days     | If Under 24<br>Hours             | Hrs. 8     | . Date of Birth<br>(Month, Day, | Year)              | 9. Bir                      | thplace (State or Foreign ountry)                  |
| Director  |                  | 243-24-2136  | XWZ  | 85                                      | Yrs.                        |                                   |                    |                                  |            | 03/24/1                         |                    | No:                         | rth Carolina                                       |
| and w   | -                | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City,                              | Town or Lo                  | cation                            |                    |                                  |            |                                 |                    |                             | 10d. Inside City Limits                            |
| Maryll<br>f sho<br>led al   | ō                | MD Prince G  | eorge's  | Ter                                     | mple H                      | Hills                             |                    |                                  |            |                                 |                    |                             | 1x Yes 2 No  |
| the the 28a-  | rec              | 10e. Street and Number   |  |   |                             | 10f. Zip                          | Code               |                                  |            | 1                               | 0a. Citiz          | en of What C                | ountry?  |
| 3a or   |                  | 3202 28th Parkway  |  |   |                             | 20                                | 0748               |                                  |            |                                 | _                  | SA                          |  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I fiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral Director | 11. Marital Status   | 12. Was Decedent   | Ever in U.S                             | 13.                         | Was Dece                          | dent of H          | ispanic Origin<br>an, Mexican, P | ? (Specil  | ty Yes or No-                   | 1                  | 4. Race - Am                |  |
| after<br>or ite   | ₫│               | 1 Never Married 2 Married  | Armed Forces?<br>1 ☐ Yes 2 ☐ I<br>If Pes, Give<br>Year or Dates: | No                                      |                             |                                   |                    |                                  | ueno Rio   | can, etc.)                      |                    | Black, Whi                  |  |
| ral", c   | <u>8</u>         | 3 ☐ Widowed 4 ☑ Divorced   | Year or Dates:   |   |                             | 1 ☐ Yes                           | 2 <b>X</b> 140     | Specify:                         |            |                                 |                    | Specify:                    | Black  |
| natu<br>Jical   | Completed by     | 15. Decedent's Ed<br>(Specify only highest gra   | ducation<br>ade completed)                                       |   | 16a. Dece                   | kind of wo                        | rk done d          | durina most of                   | workina    | - 1                             | 16b. Kir           | d of Business               | s/Industry   |
| ne.<br>• Me   | ld .             | Elementary/Secondary (0-12)  | College (1-4or 5   | i+)                                     | life.                       | DO NOT u                          | se retired         | 1)                               |            |                                 |                    | _                           |  |
| lygren her ti   |                  | 12   |  |   | Deli                        | ery                               | 1                  | 40 Mathada                       | Name //    | Tinak Adiabata I                |                    |                             | ortation   |
| ever  | Be               | 17. Father's Name (First, Middle, Last,  | ,  |   |                             |                                   |                    |                                  |            | First, Middle, I<br>ntham       | viaiden t          | Surname)                    |  |
| d Mer<br>narke  | P.               | James McKinley   | Trans Print)   |   | 10h Maille                  |                                   | /Ct4               |                                  |            |                                 | 0:1                | . T Otata                   | 7:- 0-1-1  |
| traumatic event, the Med  |                  | 19a. Informant's Name/Relationship ( Denise Hayneswort   |  | ter                                     |                             |                                   |                    | and Number o<br>kway; ]          |            |                                 |                    |                             |  |
| Health<br>em 27<br>other tra  |                  | 20a. Method of Disposition   | .II / Daugii   |   |                             |                                   |                    | •                                | Dat        |                                 |                    | cation - City o             |  |
| rages<br>nent of h<br>int: If ite<br>ury or ol  |                  | 1 Burial 2 ☐ Cremation 3 ☐   |  |   | ace of Dispo<br>metery, cre |                                   |                    | 1                                |            |                                 |                    | •                           |  |
| rtant<br>rtant<br>njury   | -                | 4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licer   |  | Arl                                     | ingtor                      |                                   |                    | ss of Facility                   | /08/:      |                                 |                    | ngton,                      | · · · · · · · · · · · · · · · · · · ·              |
| permit. Page<br>Department (<br>Important: If<br>any injury or<br>once,   |                  | emme   | Austr  | ·                                       | - 1                         |                                   |                    | Funeral                          | L Hor      |                                 |                    | -                           | Avenue N.W.<br>DC 20011                            |
|   |                  | 23a. Part1. Enter the disease, or com shock, or heart failure. List only   | plications that caused<br>one cause on each li                   | the death.<br>ne.                       | Do not ent                  | ter the mod                       | de of dyin         | ig, such as car                  | rdiac or r | espiratory arre                 | est,               |                             | Approximate<br>Interval Between<br>Onset and Death |
| hysician<br>/Medical  |                  | Immediate Cause (Final disease or condition resulting in death)  |  | poxia                                   |                             |                                   |                    |                                  |            |                                 |                    |                             |  |
| xaminer   |                  |  | Due to (or as  |   | ,                           |                                   | 1 5                |                                  |            |                                 |                    |                             |  |
| 3 中央  | <u></u>          | Sequentially list conditions,  | b. Con   |   |                             | quire                             | d Pn               | eumonia                          | a          |                                 |                    |                             |  |
| nsit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |                             |                                   |                    |                                  |            |                                 |                    |                             |  |
| al-tra  | Xar              | resulting in death) Last   | C. Due to (or as   | a consequ                               | ence of):                   |                                   |                    |                                  |            |                                 |                    |                             |  |
| j physician and<br>as the burial-transit  | la<br>Sa         |  | d  |   |                             |                                   |                    |                                  |            |                                 |                    |                             |  |
| g phy<br>as the   | edical           |  | - U  |   |                             |                                   |                    |                                  |            |                                 | -                  |                             |  |
| as been signed by the attending physician and<br>2 should be detached for use as the burial-transit   | Physician/M      | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome   |   |                             | 75                                |                    |                                  |            |                                 | 2                  | 3d. Date of de              | elivery  |
| d for   | <u>cia</u>       | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 1 □Live birth<br>4 □ Pregnant at                                 |   |                             | ⊒Ectopic pi<br>⊒ Other <i>(sp</i> |                    | '<br>                            |            |                                 |                    | Month                       | Day Year   |
| ed by the a   | hys              | 9 □ Unknown  | 9□Unknown  |   |                             |                                   |                    |                                  |            |                                 |                    |                             |  |
| signed I<br>be det  | by P             | Part II. Other significant conditions of   | contributing to death b  | ut not resul                            | ting in the u               | nderlying c                       | ause giv           | en in Part I.                    |            | 23e. Did tol                    | oacco us           | se contribute t             | to the cause of death?                             |
| on sig  |                  | Congest  | <u>ive Heath</u>   | Failu                                   | re                          |                                   |                    |                                  | _          | 1 □ Ye                          | es 2[              | ]No 3 <b>½</b> ]F           | Probably 4 □Unknown                                |
| s been s  | Completed        |  |  |   |                             |                                   |                    |                                  |            | 24a. Was a                      |                    | 24b. Were a                 | utopsy findings available                          |
| ate has<br>page 2:  | E                |  |  |   |                             |                                   |                    |                                  |            | autops<br>perform               | ned?               | prior to<br>death?<br>1 ∐Ye |  |
| certificate ha  | Be               | 25. Was case referred to medical   |  |   |                             |                                   |                    | 26. Place of                     | Death /    | 1□ Yes :<br>Check only on       |                    | 1116                        | 5 2 110  |
| is certific<br>director,  | LOB<br>P         | examiner?<br>1 ☐ Yes 2 ∰ No  | Hospital:  | ent 2 E                                 | R/Outpatier                 | nt 3 DC                           | OA Oth             | or.                              |            | 5 Reside                        |                    | □Other (Sp                  | ecify)   |
| <u>a</u>  |                  | 27. Manner of Death  | 28a. Date of Inju<br>(Month, Da                                  |   | 28b. Time o                 | f 2                               | 28c. Injur<br>Worl |                                  |            | d. Describe ho                  |                    |                             | ,  |
| tor: Af<br>the fur  | atio             | 1 Natural 5 Pending<br>2 Accident investigation  | ו ו  | y rour)                                 | injury                      | M                                 |                    | Yes 2 □ No                       |            |                                 |                    |                             |  |
| after death.  Director: After in by the fune  | Certification:   | 3 ☐ Suicide 6 ☐ Could not be determined  | 28e. Place of injuding, et                                       |   |                             | eet, factor                       | y, office          |                                  | 28f        | f. Location (St<br>City or Town |                    |                             | Bural Route Number,                                |
| rs after<br>al Dire   | Ger              |  |  | , |                             |                                   |                    |                                  |            | , 5. 1041                       | , 5.2.0/           |                             |  |
| within 24 hours after d<br>To the Funeral Direct<br>completely filled in by   |                  | (Check only 2 Medical Exar   | nysteian: To the best<br>niner: On the basis o                   | of my know<br>f examinati               | ledge, deat<br>on and/or in | h occurred                        | at the tir         | me, date and p                   | olace, an  | d due to the c                  | ause(s)<br>ate and | and manner a                | as stated.   |
| hin 2<br>the<br>nplet   | Medical          | one)   | and manner sta   |   |                             |                                   |                    |                                  |            |                                 |                    |                             |  |
| Son 7 with  | -                | 29b. Signature and title of certifier  | 1/ -   |   |                             | 290                               | . Licens           | e number                         |            | 2                               | ed. Date           | signed (Mon                 | th, Day, Year)                                     |

State Registrar 30. Name and address of per-

Vikas Jígi 1500 Forest Glen Rd. Sílver Spring, Md. 20910 31. Date filed (Month, Day Year) AUG 1 5 2007

32 Registrar's Signature

pleted cause of death (Item 23a) (Type, Print)

D0064174

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Year **Physician** MAYNOR 09 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RIDGEWAY MANOR NSG. BALTIMERE = KEHAB If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace **Funeral** 212-12-4611 Hours 1**X**M 2□ F Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits treumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USM Funeral 12. Was Decedent Eve Armed Forces? 1 Yes 2 ☐ No If Yes, Give Year or Dates: or Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Ever in U.S. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 13lack 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 le marked other than ' College (1-4or 5+) Techanic rode 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) god Free Maynor 19a. Informant's Name/Relatio ship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, nt of Health a t: If item 27 le y or other tree 608 MS 21225 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) HOU 21. Signature of Funeral Service Licenses arris 23a. Pari 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Boach **Physician** ew months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? ( ere how knowlen 2X No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 📆 No 1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 2 Accident 5 Pending investigation s after dec. 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours aft To the Funerel Di completely filled in 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number August 14, 2007 12754

State

Site 4 A , Baltimoni, MD-21227

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OEETMA RAJA MD 4367 Hallim Terry Rd

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Marks dward 7:45a 10 2007 August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3611 Hernwood Road Baltimore Woodstock 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, ) Sept 18, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 □ M 2 □ F 320-09-5714 86 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Woodstock 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3611 Hernwood Road 21163 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □Wes 2 □ No If Yes, Give Year or Dates: WWI Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No White Specify: 3 ☐ Widowed 4 ☐ Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Accoutns Payable Clerk Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Charles Marks Clara Freida Dreier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lillian K. Marks (Wife) 3611 Hernwood Road Woodstock, MD 21163 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park 8/14/2007 Sykesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee PA Address of Facility HOME & CHAPEL, PA (Box 195 Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cov 95+ive
Due to (or as a Sequence of): Tens Schemic cardiolyopathy if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1☐ Yes 2☐ No Month Day 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Mo 24a. Was an autopsy 1∏ Yes 2 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 3□ DOA 2 ER/Outpatient 5 Aesidence 6 □Other (Specify)

**Physician** /Medicai Examiner

permit. Pages 1 and Department of Healt Important: If Item 27 any Injury or other t once.

**Physician** 

/Medical

10a State

Director

Completed by Funeral

Be

MD

**Examiner** 

**Funeral** 

Director

"natural", or items 23a or 28a-f sh edical Examiner must be notified

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene.
Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner the burial-tran Physician/Medical þ Completed Be Certification: To nours after death.

neral Director: After this
filled in by the funeral d

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner? Other: 4 \( \sum \) Nursing Home 1 Yes 2 No 28d. Describe how injury occurred

27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 4 Homicide

28b. Time of Injury Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

29b. Signature and tyle of co

AUG

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

ELDERS Lurg Swite 2247207 106 31. Date filed (Month, Day, 32. Registrar's Signature

State Registrar

Medical

To the Hospital o within 24 hours aft To the Funeral DI completely filled in

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 8 per fb. 2878.04/08/08dhb 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2007 226 P Month **Physician** ROBER AUGUST /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALTIMORE 6000 SAMARITAN 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Days Hours Min. 1 M 2□F Yrs. 03/15/1918 249-16-5067 89 SouthCarolina Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Director N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21239 U.S.A. 1525 Sherwood Ave. Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 ☐ No Specify. Baltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BethlehemSteel Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lauvenia 2 Andrew Morrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 1525 Sherwood Ave. Baltimore, Md 21239 Herman J. Gadson/nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 □Removal from State 1 ☐ Burial 2 ☐ Cremation ArbutusMem.Park Aug.17,2007 Baltimore, Md 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servi ... icensee CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. Balto. Md 21213 Approximate Interval Between Onset and Death ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part I. Enter the disease, or complications that shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) ASPIRATION PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the r IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown as been signed by the 2 should be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARDIOMYOPATHY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed RENAL INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate has funeral director, page 2 DIFFICILE ENTERITIS CLOSTRIDIUM 1□ Yes 2 1 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | ■ N 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28d. Describe how injury occurred 27. Manner eath 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

within 24 hours after death To the Funeral Director: Hospital

filled in by completely

State Registrar 29b. Signature and

O. SECT LOCHRANEN BLUD BALTIMORE MO 21239 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

32. Registrar's Signature House S.

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death **Physician** 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner IMON dicA 0 7 m If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X**M 2□F Months Days Hours Director 5 Mashington, D.C Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ane. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Funeral Director Windsor Mil altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3/04 Northmant Thood 21244 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Ves 2 No If Yes Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify If **▼**es, Give Year or Dates: þ Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) echnician Computer Lars 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hnthony 2 Allan Magruder een Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mid . Magrueler Viana i Windscrmill MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 08.19.2009 Quings mills MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility V Church C. Greene Julieral Service 21. Signature of Funeral Service Licensee aughn 81 And Trandallisten mo i berty 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10dA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page certificate 2 No director 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 []/Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Marmer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Injury 1 Natural M 1 □ Yes 2 □ No offer death.

Ofrector: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours aff To the Funeral Or completely filled in 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar 30 Name and address of person

Year)

1

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                     |   | •  | For<br>State<br>Registrar   | State of Ma   | •                           | Certificate                               |                               |  |  | Reg. No.                             | 1/ 25160   |
|---------------------|---|--|---|---|-----------------------------|---|-------------------------------|--|--|--------------------------------------|--|
|                     | Dhariai   |  | 1. Decedent's Name (First, Middle, Last   | )   |                             |   |                               |  | 2. Date of Dea<br>Month                |                                      | 3. Time of Death   |
|                     | Physicia<br>/Medic  | al   | Robert Muir,  |   |                             |   |                               |  | August                                 |                                      | 07 10:15 P <sup>M</sup>  |
|                     | Examin  | er   | 4a. Facility Name (If not institution, give   |   |                             |   |                               | cation of Death                        |  | 4c. County o                         |  |
|                     |   |  | Frederick Mem  5. Social Security Number 6. Se  |   | ital<br>(In yrs. last birth |   | deric                         | CK<br>f Under 24 Hrs.                  | 8. Date of Birth                       | Frede                                | 9. Birthplace (State or Foreign  |
|                     | Funeral<br>Director   |  | 219-14-5672   | M 2□F   | 84 Y                        | Months [                                  |                               | Hours Min.                             | (Month, Da)<br>March 2                 | (, Year)                             | Maryland   |
|                     | aryland<br>show<br>d at   | 70   | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. City, Town             |   |                               |  |  |                                      | 10d. Inside City Limits 1 ☐ Yes 2X No  |
|                     | he M<br>8a-f<br>otifie  | Director   | Maryland Frederi  10e. Street and Number  | ck  |                             | Monrovia                                  |                               |  |  | 10g. Citizen of WI                   | hat Country?   |
|                     | a or 2  | ä  | 5010 Waxton Court   |   |                             | Toi. Lip o                                | 217                           | 70                                     |  | United S                             |  |
|                     | eath  | era  | 11. Marital Status  | 12. Was Decedent E  | ver in U.S.                 | 13. Was Deceder<br>If Yes, specify        |                               |  |  |                                      | - American Indian,   |
| 20                  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral   | 1 □ Never Married 2123 Married 3 □ Widowed 4 □ Divorced   | Armed Forces? 1XXYes 2 □ N If Yes, Give Year or Dates: V        |                             | If Yes, specify                           |                               | Mexican, Puerto<br>Specify:            | Hican, etc.)                           | Specify:                             | , White, etc. White  |
| ş                   | 2 hou   | be   | 15. Decedent's Ed   | ucation   | 16a. L                      | Decedent's Usual                          | Occupation dur                | on<br>ring most of work                | ina I                                  | 16b. Kind of Bus                     |  |
| ת<br>מ              | hin 7.<br>9.<br>Medi  | Completed  | (Specify only highest grade Elementary/Secondary (0-12)   | College (1-4or 5-   | +)                          | Give kind of work<br>life. DO NOT use     | retired)                      | nig most of work                       | "'y                                    |                                      | ıs Material<br>nsportation   |
| 7                   | yd wit<br>gien<br>ger th  | ĕ  | 10  |   | Tr                          | <u>uck Driv</u>                           |                               | - ** ** * * **                         | /5' 1 A A'-1-11-                       |                                      |  |
| 3                   | be file<br>tal Hy<br>d oth  | Be   | 17. Father's Name (First, Middle, Last) James Gordon Muir,  | Sr  |                             |   |                               |  | •                                      | Maiden Surname<br>L McKinle          |  |
| λ                   | ould<br>Men<br>narke  | 은  |   |   | 106                         | Mailing Address (                         |                               |  |  |                                      |  |
| Maryland 21215-0036 | 12 sh<br>h and<br>7 is n<br>traun   |  | 19a. Informant's Name/Relationship (7) Eleanor L. Muir /  |   | 7.4                         | 0 Waxton                                  |                               |  |  |                                      | , and a second   |
| <u>က်</u>           | s 1 and 2<br>of Health a<br>item 27 is  |  | 20a. Method of Disposition  |   | 20h Dingo of                | Disposition (Mamo                         | of.                           |  | Date                                   |                                      | City or Town, State  |
| baltimore,          | Pages<br>tment of<br>tant: If It<br>jury or o   | 20a. Method of Disposition   20a. Method of |   |   |                             |   |                               |  |  |                                      |  |
| מ                   | permit<br>Depar<br>Impor<br>any In  |  | 21. Signature of Funeral Service I cen  | see   |                             | Resthav<br>9501 Ca                        | en F                          | unëral S<br>in Mtn.                    | Services<br>Hwy. Fi                    | s, Skkot<br>rederick                 | Cody P.A.<br>, MD 21701  |
|                     |   | 8  | 23a. Part. Enter the disease or comp<br>shock, or heart failure. List only  | olications that caused<br>one cause on each lin                 | the death. Do no            | ot enter the mode                         | of dying,                     | such as cardiac                        | or respiratory a                       | rrest,                               | Approximate<br>Interval Between<br>Onset and Death                           |
|                     | Physician /Medical  |  | immediate Cause (Final disease or condition resulting in death)   | a   |                             | DIAL                                      | 1                             | NFAR                                   | 1011                                   | 00                                   | 3 VAYS   |
|                     | Examiner  |  | <b>1</b>  |   | onsequence o                | AR  | TFI                           | RY P                                   | ISFA                                   | A2.                                  | ·  |
|                     | STORE TO  | ē  | Sequentially list conditions, if any, leading to immediate  | D   | a consequence               |   | , ,                           | 1                                      | , 0 0 1                                |                                      |  |
| J                   | uted<br>d<br>ansit  | Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | C   |                             |   |                               |  |  |                                      |  |
| Ď,                  | tificate be executed<br>g physician and<br>as the burial-transit  | I Exa  | resulting in death) Last  | Due to (or as   | a consequence o             | f):                                       |                               |  |  |                                      |  |
| 68/60,              | cate b  | edical   |   | d   |                             |   |                               |  |  |                                      |  |
| . Box               | The law requires that the death certifinate has been signed by the attending I age 2 should be detached for use as  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ □ Unknown   | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown | 2 Fetal death               | 3 ☐ Ectopic pre<br>5 ☐ Other (spe         |                               |  |  | 23d. Date<br>Mor                     | e of delivery<br>nth Day Year  |
| S, P.O              | ires that the signed by   | þ  | Part ii. Other significant conditions   | ontributing to death bu   | ut not resulting in         | the underlying car                        | use given                     | in Part I.                             |  |                                      | ibute to the cause of death? 3 ☐ Probably 4 ☑Unknown                         |
| or Vital Records,   | w requir<br>been si<br>should I   | Completed  |   |   |                             |   |                               |  | 24a. Was                               |                                      |  |
| Tec                 | has the 2 s   | mple   |   |   |                             |   |                               |  | auto<br>perfe                          | psy prmed?                           | Were autopsy findings available<br>prior to completion of cause of<br>death? |
| <u></u>             |   |  | OF Management to medical  |   |                             |   |                               | 26. Place of Dea                       | 1  Yes                                 | ,                                    | ☐Yes 2 No  |
|                     |   | Be   | 25. Was case referred to medical examiner?  1 Yes 2 No  | Hospital:   | ent 2 🗆 EB/Out              | tpatient 3 DO/                            | 0.1                           |  |  | idence 6 □Oth                        | er (Specify)   |
| ō                   | Physer this eral di   | . To   | 27. Manner of Death   | 28a. Date of Inju   | ry 28b. T                   | ime of 28                                 | Bc. Injury<br>Work?           |  |  | how injury occurr                    |  |
| 0                   | nding I<br>th.<br>r: After<br>e funer   | ţi   | 1 Natural 5 Pending<br>2 Accident investigation   | (Month, Da  | y rear) 11                  | njury<br>M                                |                               | es 2 □ No                              |  |                                      |  |
| Division            | Hospital or Attending<br>14 hours after death.<br>Funeral Director: After<br>tely filled in by the fune   | Certification:   | 3 Suicide 6 Could not b<br>4 Homicide determined  | rm, street, factory,  | , office                    |   | 28f. Location (<br>City or To | (Street and Numb<br>wn, State)         | er or Rural Route Number,              |                                      |  |
| _                   | To the Hospital or Attendir within 24 hours after death.  To the Funeral Director: Al completely filled in by the fu  | Medical C  | 29a. Certifier 1 Certifying Pl<br>(Check only one) 2 Medical Examone)   | nysician: To the best<br>miner: On the basis o<br>and manner st | f examination an            | , death occurred a<br>d/or investigation, | at the time<br>, in my op     | e, date and place<br>inion, death occu | e, and due to the<br>urred at the time | cause(s) and ma<br>, date and place, | anner as stated.<br>and due to the cause(s)                                  |
|                     | o the   | Mec  | 29b. Signature and title of certifier   |   |                             | 29c.                                      | . License                     | number                                 |  | -                                    | d (Month, Day, Year)   |
|                     | F ≯ F ŏ   |  | <b>N O 3</b>  | 3   | 08                          | 11312007                                  |                               |  |  |                                      |  |
| 1                   | 14.   |  | 30. Name and address of person who  | completed cause of d  | leath (Item 23a) (          |   |                               |  |  |                                      |  |
|                     | 10,   |  | Safrina Hasan, M.   |   |                             |   | erick                         | , MD 21                                | 701                                    |                                      |  |
|                     |   | ate  | 31. Date filed (Month, Day, Year)   | 32. Registr   | ar's Signature              | - A-R                                     |                               |  |  |                                      |  |
|                     | Regist  | rar  | T T SILV  | 2007  | 10                          | A. a. M                                   |                               |  |  |                                      |  |

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.4. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 18 Donald H Morris Jr. 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death Examiner Doctors Hosital Lanham, Maryland Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth **Funeral** Months Days Hours 1 X M 2 ☐ F 0370971971 229-41-0529 36 Charlottesville Director Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Director 1X Yes 2 No MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9521 Purple Cloud Row 20723 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Kodax 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ <u>Donald H Morris SR.</u> <u>Mildred Harris</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KiKi Foster-Morris ( Wife) 9521 Purple Cloud Row Laurel Md 20723 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 8/16/07 Gilliam BC Cemetery Μt Louisa, Virginia 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licensee Terry A Austin <u>3821 14th Street N W Washington, D C 20011</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Acidosis Metabolic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner toiluxe Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Exami ordiomyopoth Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s performed' certificate 2 🗆 No 2□No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1X Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred A fter 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 🛮 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours americal To the Funeral Director: Aft Fo the

State Registrar

29c. License number

MDD 63157

RUAD

LANHAM,

29d. Date signed (Month, Day, Year)

30. Name and address of persog who completed cause of death (Item 23a) (Type, Print)

8100 GOOD

32. Registrar's Signature

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🔠 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2 August **Physician** 2007 6:30 pm Capt. Frank M. McCabe /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Arden Courts Pikesville Baltimore 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1**X** M 2□ F 96 Yrs. 263-60-3958 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ehow. item 27 ie markad othar than "neturel", or Iteme 23a or 28a-f ebov other treumatic event, the Madical Examinar must be notified at Baltimore Md. Pikesville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8909 Reisterstown Rd. 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Heelth and Mental Hygiene. Int: If item 27 Ie markad other than "neturel", or Ite 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +4 Captain US Coast Guard 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank T. McCabe Anna M. Murray 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carolyn Bartholme/ Daughter 215 Meadowvale Rd. Lutherville, Md. 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 XBurial 2 Cremation 3 Removal from State permit. Page Depertment o Importent: If eny injury or once. Arlington Nat. Cemetery 11-13-07 Arlington, Va. 4 □ Donation 5 □ Other (Specify) <sup>22. Name</sup> and Address of Facility Runeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral 3 Nice Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause operach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence ol): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificete hes 1 Yes 2/No : After this certification tuneral director. To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) ASS 15 TWO 1 Yes 2 No 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred LIVEUR Certification; 1 Natural Injury 5 Pending efter death. Director: Af 1 Tes 2 No 2 Accident investigation 3 ☐ Suicide 6 Could not be determined 28e. Place ol Injury - At home, farm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours el 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10+1 30. Name and address of person who completed cause of seath (Item 23a) (Type, Print) DUIUM 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar

07-05971 Carol Monroe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 26168

|  |                | r State  |                             |                          | _                      |                              | Certific                              | cate of l              | Death                            |                      |                          | 12                   |  | eg. No.                      |                   |                       | 3. Time of Death                    |        |
|--|----------------|--|-----------------------------|--------------------------|------------------------|------------------------------|---------------------------------------|------------------------|----------------------------------|----------------------|--------------------------|----------------------|--|------------------------------|-------------------|-----------------------|-------------------------------------|--------|
| Physician/   | 1. D           | arol Ann Monroe  2. Date of Death Month Day Year August 4, 2007  Lt. Ch. Teun or Location of Death 4c. County of   |                             |                          |                        |                              |                                       |                        |                                  |                      | ar                       | 1130 hrs             |  |                              |                   |                       |                                     |        |
| ,  | 4a.            | Facility Name (i<br>2400 Linder  | if not institution          | n, give stre             | eet and nu             | ımber)                       |                                       | 41                     | o. City, Tow<br>Baltimo          |                      | ocation of               |                      | A.T.   |                              | N/A               |                       |                                     |        |
| Pinnetar   | 5. S           | ocial Security N   | Number                      | 6. Sex                   |                        | 7. Age (In                   | yrs. last b                           | irthday)<br>Yrs.       | If Under                         | 1 Year<br>Days       | If Under<br>Hours        | 24Hrs.<br>Min.       | 8. Date of Bi  |                              |                   | Foreig                | hplace (State or<br>in<br>untry) Md |        |
|  | Usu            | L6-84-<br>ual Residence o  | of Decedent                 | 1M                       | 2 <b>X X</b>           | 100                          | 46                                    | vn or Location         | n                                |                      |                          |                      | 0/20   |                              |                   | -                     | 10d. Inside City                    | Limits |
| * a  | 10a            | Md   | 10b. County N/A             |                          |                        | 100                          | •                                     | timor                  |                                  |                      |                          |                      |  |                              |                   |                       | 1 X Yes 2                           | No     |
| the Maryland<br>a or 28a-f sh<br>tified at one<br>Director   |                | e. Street and Nu   |                             |                          |                        |                              |                                       |                        | 10f. Zip C                       |                      |                          |                      |  | 10g. Cr<br>US                | tizen of V        | nat Cour              |                                     |        |
| h with the Maryland ems 23a or 28a-f show a t be notified at once.  eral Director  | 11.            | 400 Li<br>Marital Status   |                             | Aven                     | 2. Was De              | ecedent Eve<br>Forces?       | er in U.S.                            | 13. Was                | 212<br>s Decedent<br>es, specify | of Hist              | oanic Origi<br>Mexican,  | n? ( Spe<br>Puerto F | ecify Yes or N<br>Rican, etc.)                                   |                              | 14. Rad           | e - Amer<br>ite, etc. | ican Indian, Black                  | ,      |
| er deat<br>or its<br>r mus<br>Fur  | 1              | XNever Marr  |                             | farried 1<br>vorced If Y | Yes<br>Yes, Give Ye    | $2\overline{X}$              |                                       | 1                      | Yes 2X                           | No                   | specify:                 |                      |  |                              |                   | Bla                   |                                     |        |
| nours after natural" xamine ed by  | -              | 5. Decedent's E  | Education (Sp               | ecify only l             | nighest gr             |                              |                                       | a. Deceden<br>during m | t's Usual O<br>ost of work       | ccupati<br>ing life. | on (Give k<br>DO NOT     | ind of wo            | ork done<br>ed)  | 16b                          | . Kind of I       | Business/             | /Industry                           |        |
| ed within 72 hours<br>lygiene.<br>other than "natu<br>hy Medical Exan<br>Completed   |                | Elementary/Sec<br>12   |                             |                          | College                | (14010)                      |                                       | Homen                  | naker                            | •                    | 10 Mothor                | s Name               | (First, Middle   | Maide                        | Own               |                       | ne                                  |        |
| be filed wintal Hygien rked other ent, the MBE COL   |                | Father's Name  |                             |                          |                        |                              |                                       |                        |                                  | 1,                   | Marn                     | ner                  | rite Monroe r Rural Route Number, City or Town, State, Zip Code) |                              |                   |                       |                                     |        |
| hould be<br>nd Menti<br>is mark<br>is mark<br>affic ever   | 19             | la. Informant's N  | Name/Relation               | nship (Type              |                        | -                            |                                       |                        |                                  |                      |                          |                      |  |                              |                   |                       | or Town, State                      |        |
| l and 2 s<br>Health ar<br>item 27<br>r traum   | 20             | Marque<br>Da. Method of D  | erite bisposition  XCremati |                          |                        | from State                   | cre                                   | matory or ot           | ther place)                      | 0 00                 | .,,,,,,                  |                      |  | - 1                          |                   |                       |                                     |        |
| Pages<br>ment of<br>tant: If<br>or othe  | 1,             |  | 5 Other                     | Specify:                 | _                      | - /                          | Me                                    | tro (                  | Crema                            | Address              | ry<br>s of Facilit       | 8/7                  | /2007  | Ca                           | uton              | SV1                   | lle,Md.                             |        |
| permit<br>Depart<br>Impor<br>injury  | -17            | 1/1 00   | 1 / /                       | 1.                       |                        | 518                          | 210                                   | F                      | 366p                             | Eut                  | aw P                     | rs<br>lac            | Funer<br>e, Bal  | tin<br>arrest                | nore<br>shock, or | heart                 | Apploximate                         | inter  |
| ysician<br><i>I</i> ledical  | ı              |  | only one cau                | se on each               |                        | it caused th                 |                                       |                        | the mode c                       | n dynng:             | , suom us v              |                      |  |                              |                   |                       | Between On<br>Deat                  |        |
| xaminer  | lr<br>o        | or condition resulting in death)  Due to (or as a consequence of):   |                             |                          |                        |                              |                                       |                        |                                  |                      |                          |                      |  |                              |                   |                       |                                     |        |
| ner  | iii            | equentially list<br>fany, leading to<br>ause. Enter Ur   | immediate                   |                          | ue to (or a            | is a conseq                  | quence of):                           |                        |                                  |                      | 11.1                     |                      | e II   |                              |                   |                       |                                     |        |
| ed sit   | Yalli          | Disease or injure<br>events resulting  | ry that initiate            | d . D                    |                        | as a consec                  |                                       |                        |                                  |                      |                          |                      |  |                              |                   |                       |                                     |        |
| physician and the burial - transit   | - 1            | X UNPEND   | ED                          |                          |                        |                              |                                       | e g870<br>perME.e      | <b>) 8-1</b><br>870, 8           | <b>5-07</b><br>3/16/ | <b>vt</b><br>07_TT       |                      |  |                              | 334 Da            | te of deliv           | verv                                |        |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burus after death certificate be executed within 24 burus after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director. |                | F FEMALE:<br>3b. Was deced-<br>past 12 mor   | ent pregnant i              | n the                    | 1 Li                   | es, outcom<br>ve birth       | e of pregna                           | ancy<br>2 F            | Fetal death                      | 3                    | Ector                    | oic pregn            | ancy   |                              | Mon               |                       |                                     | Year   |
| the attending led for use as the   |                | 1 Yes 2  | No 9 🗸                      |                          | 9 u                    | regnant at t                 |                                       |                        | Other (Spe                       |                      |                          | D-41                 | 230  | id toba                      | acco use          | contribute            | e to the cause of d                 | eath'  |
| es that the deigned by the se detached for   |                | Part II. Other s   | ignificant coi              | nditions                 | contributi             | ng to death                  | but not re                            | sulting in the         | e underlyin                      | g cause              | e given in i             | Part I.              |  |                              | 2 🗸 No            | 3 F                   | Probably 4 U                        | Inkno  |
| w requires that i  | Completed by   |  |                             |                          |                        |                              |                                       |                        |                                  |                      |                          |                      | a  | Vas an<br>autopsy<br>perform |                   | 4b. Were prior deat   |                                     | cause  |
| certificate has  |                |  |                             |                          |                        |                              |                                       |                        |                                  | 26.Pla               | ice of Dea               | th (Chec             |  | es 2                         |                   | 1 🗸                   | Yes 2                               | No     |
| ysician: The list certificate director, page   | 8              | 25. Was case r<br>examiner?<br>1 ✓ Yes   | referred to me              |                          | lospital: <sub>1</sub> | Inpatie                      | ent 2                                 | ER/Outpation           |                                  | DOA                  | Other <sub>4</sub>       | Nurs                 | sing Home  |                              |                   |                       | Other: Scene                        |        |
| ding Phy<br>After ti<br>funeral  | on: To         | 27. Manner of I  |                             | Pending                  | (1                     | Date of Inju<br>Month, Day,Y | 'ear)                                 | 28b. Time<br>Fnd 11    |                                  | 1                    | Yes 2                    |                      | unk  |                              |                   |                       |                                     |        |
| LIVISION OF VICAL RECORDS  tal or Attending Physician: The law require and Brierctor: After this certificate has been s led in by the funeral director, page 2 should 1  | Certification: | Pending Investigation  Accident  Accident  Suicide  Pending Investigation  Find 8/4/2007 Find 11:10 am  Find 8/4/2007 Find 11:10 am  28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Town, State)  2400 Linden Ave. Be |                             |                          |                        |                              |                                       |                        |                                  |                      |                          |                      |  |                              |                   |                       |                                     |        |
| ospital of hours all uneral I  |                | 4 Homic  | ide                         | determine                | 1 1                    |                              | louse<br>y knowled                    | ge, death or           | ccurred at t                     | he time              | , date and               | place, a             | and due to the   | cause                        | (s) and m         | anner as              | stated.                             |        |
| Division of view the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral  | Medical        |  | Medical                     | Examine                  | r:On the b             | asis of exa                  | mination a                            | nd/or invest           | igation, in                      | iny opii             | nion, death<br>ense numb |                      | d at the time,   | gate a                       |                   |                       | to the cause(s)  (Month, Day, Yea   | r)     |
|  | Σ              | 29b. Signature   | Munte                       | - 1                      | e K                    | ull                          |                                       |                        |                                  | O.                   | C.M.E.                   |                      |  |                              | Augus             | t 5, 20               | 07                                  |        |
| and I  |                | 30. Name and   | address of pe               |                          | complete               | d cause of                   | death (Iten                           | n 23a)<br>ner 11       | 1 Penn S                         | Street               | , Baltim                 | ore, M               | D 21201  |                              |                   |                       |                                     |        |
| Str  | ate            | Od Data Stad   |                             | W.                       |                        | 32. Registic                 |                                       |                        | B                                | -                    |                          |                      |  |                              |                   | ОСМ                   | F                                   |        |
| Regist   |                |  | AUG                         | 15                       | 2007                   | A 15 mg                      | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | ORIGI                  | NAL                              | 2                    |                          |                      |  | _                            |                   |                       | · Ma.                               |        |

|   |   |                | - State<br>Registrar   |                          |  |                             | (                          | Cer           | tificat                                     | e of l                  | Death                              | 7                  |   | Reg. No.                    | 001                                      | .010.  |   |
|---|---|----------------|--|--------------------------|--|-----------------------------|----------------------------|---------------|---|-------------------------|------------------------------------|--------------------|---|-----------------------------|--|--|---|
|   | Physici<br>/Medic   |                | 1. Decedent's Name<br>Lawrenc  | (First, Middle,<br>Le Le | oñard  | Mack                        | , Sr.                      |               |   |                         |                                    |                    | 2. Date of Do                           | 0 8 ay                      | 0 7 <sup>ear</sup>                       | 3. Time of Death 6:40p M                           | 1 |
| )   | Examin  |                | 4a. Facility Name (If I<br>Southern  | not institution,<br>Mary | give street and nu<br>land Ho                                  | spit                        | al                         |               |   | Town, or<br>lin         |                                    | of Death           |   |                             | ounty of Dear                            | h  |   |
| 12.0  | Funeral<br>Director   |                | 9 Social Sesurity No   |                          | 6. Sex<br>1☐M 2☐F  | 7. Age (ir.                 | yrs. last birtl            | hday)<br>(rs. | If Under<br>Months                          | 1 Year<br>Days          | If Unde<br>Hours                   | er 24 Hrs.<br>Min. | 8. Date of Bi<br>(Month, D<br>0 1 – 2 9 | rth<br>ay, Year)<br>- 1941  | 9. Birl<br>Wasi                          | hplace (State or Foreign<br>untry) DC              | n |
| D   | >   |                | Usual Residence of I   | Decedent<br>10b. County  |  | 10                          | c. City, Town              | orloc         | ration                                      |                         |                                    |                    |   |                             |  | 10d. Inside City Limits                            |   |
| e Marvia  | 8a-f shov   | Director       | MD   |                          | PG   |                             | o. Oly, 10111              |               | empl  |                         | ills                               | ;                  |   |                             |  | 1¥EYes 2 ☐ No                                      |   |
| th with th  | 23a or 2  |                | 45T7 Bir   | chtre                    | e Lane   |                             |                            |               | 10f. Zip                                    | Code                    | 207                                | 48                 |   | 10g. Citize                 | of What Co<br>USA                        | untry?   |   |
| <b>036</b><br>urs after dea   | Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral     | 11. Marital Status 1 X Never Marrie 3 ☐ Widowed  |                          | 12. Was Dec<br>Armed F<br>ed 1 ☐ Yes<br>If Yes, G<br>Year or I | orces?<br>2 No<br>live      | in U.S.                    | 1             | Vas Dece<br>f Yes, spe<br>I □ Yes           |                         | ispanic O<br>an, Mexica<br>Specifi |                    | ecify Yes or N<br>Rican, etc.)          |                             | I. Race - Ame<br>Black, Whit<br>Specify: |  |   |
| Baltimore, Maryland 21215-0036  | ene.<br>than "natur<br>ne Medical   | Completed      | (Special Special Speci |                          | t grade completed  | )<br>(1-4or 5+)             |                            | (Give I       | lent's Usu<br>kind of wo<br>DO NOT u<br>Sit | rk done d<br>se retired | during ma<br>I)                    | ost of worki       | ing                                     | 1                           | of Business,<br>ernmei                   |  |   |
| land 2  | lental Hygie<br>ked other<br>Ic event, th   | To Be Co       | 17. Father's Name (  | First Middle, l          | <sup>Last)</sup> Mims  |                             |                            |               |   |                         |                                    | her's Name         | (First, Middle                          | HELM <i>I</i>               |  | CK   | _ |
| Mary  | alth and M<br>27 Is mar<br>r traumat  |                | 19a. Informant's Nai<br>Barbara  | me/Relationsh<br>Jacks   | ip <i>(Type. Print)</i><br>On <b>,</b> Sis                     | ter                         | 4 5 T                      | Mailin<br>7 E | g Address<br>Birc                           | (Street<br>htre         | and Num<br>ee L                    | ber or Rura<br>ane | Templ                                   | ber, City or<br><b>e Hi</b> | Town, State,<br>LIS, Î                   | Zip Code)<br>1D 20748                              |   |
| nore,   | nent of Hea   |                | 20a. Method of Dispo<br>1 ☐ Surial 2 ☐<br>4 ☐ Donation   | Cremation                | 3 □Removal from  | n State                     | 20b. Place of cemeter.     | l n           | natory or o<br>Mem                          | other plac<br>Or 1 a    | a)                                 | 8-16               | Date - 0 7                              | Suit                        | ation - City or                          | . MD   |   |
| Baltin  | Departm<br>Importar<br>any Inju   |                | 21. Signature of Fur   |                          |  | у                           |                            | 1 (           | . Name ar                                   | nd Addre                | ss of Fac                          | Rona<br>Ave        | ld Ta                                   | <del>ylor</del><br>ltimo    | ore, N                                   | HD 21201   |   |
| 120   | - UP  |                | 23a. Part1. Enter the shock, or hear   | e disease, or            | complication that  | caused the                  | death. Do n                | ot ente       | er the mod                                  | de of dyir              | ng, such a                         | as cardiac         | or respiratory                          | arrest,                     |  | Approximate  |   |
| PI  | hysician  |                | Immediate Cause (F   | Final                    |  |                             | MYUC                       |               |   |                         |                                    |                    |   |                             |  | Interval Between<br>Onset and Death                |   |
| 110   | /Medical<br>xaminer   |                | resulting in death)  |                          |  |                             | nsequence o                |               |   |                         |                                    |                    |   |                             |  |  |   |
| - T   | Adminer   | je je          | Sequentially list con  | nditions,                |  | 20N A                       | mey<br>insequence of       |               | TER   | 4 0                     | ISEA                               | HU                 |   |                             |  |  | _ |
| petri   | d<br>ansit  | Examiner       | if any, leading to imicause. Enter Under Cause (Disease or in that initiated events  | njurv                    | 6  | ,                           | ·                          |               |   |                         |                                    |                    |   |                             |  |  |   |
| X 68760,<br>certificate be executed   | nding physician and use as the burial-transit   | sal Exa        | resulting in death) Li   | ast                      | Due to   | or as a co                  | nsequence o                | of):          |   |                         |                                    |                    |   |                             |  |  |   |
| 689<br>Illicat  | g phy<br>as the   | /Medical       |  |                          |  |                             |                            |               |   |                         |                                    |                    |   |                             |  |  |   |
| ရှိ   |   | Physician/M    | IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 ☐ Unknown  | months?                  |  | birth 2 nant at tim         | Fetal death                |               | ]Ectopic p<br>] Other (s <sub>i</sub>       |                         | /                                  |                    |   | 23                          | 3d. Date of de<br>Month                  | livery<br>Day Year                                 |   |
| <b>.</b> that t   | ned by  |                | Part II. Other signifi   | icant conditio           | ns contributing to   | death but n                 | ot resulting in            | the ur        | nderlying o                                 | ause giv                | en in Par                          | t I.               | 23e. Did                                | tobacco us                  | e contribute t                           | o the cause of death?                              |   |
| rds   | en sign   | ed b           | DIA  | BETE                     | S  |                             |                            |               |   |                         |                                    |                    | 1                                       | Yes 2                       | No 3□P                                   | robably 4XUnknow                                   | n |
| Division or Vital Records, P.O. or Attending Physician: The law requires that the d | has ber   | Completed by   | CONS   | ESTIV                    | E HEM  | et F                        | AILUR                      | 6             |   |                         |                                    |                    | 24a. Wa                                 | onsv                        | 24b. Were a prior to death?              | utopsy findings availabl<br>completion of cause of | е |
| a E   | ficate<br>r, pag  |                | 25. Was case referr  | and to madical           |  |                             |                            |               |   |                         | 00 PI                              | / D                |   |                             | 1 ☐ Yes                                  | No 2 No  |   |
| Vital<br>Sicial   | s certi<br>irecto   | o Be           | examiner?  |                          | Hospital: 1 F  | ] Inpatient                 | 2 FR/Out                   | tnatien       | nt 3□ D0                                    | Oth                     | or.                                |                    | h <i>(Check only</i><br>me 5 ☐ Res      |                             | □Othor /Sn                               | aciful   |   |
| O   | er this   | I              | 27. Manner of Death  | 1                        | 28a. Dat   | e of Injury<br>onth, Day Ye | 28b. T                     | ime of        |   | 28c. Injui<br>Wor       |                                    |                    | 28d. Describe                           |                             |  | - City)  |   |
| vision or Vita  | or: Aft<br>he fur   | atio           | 1  | 5 Pending investig       | ation  |                             |                            |               | М   | 1 🗆                     | Yes 2[                             | □No                |   |                             |  |  |   |
| Divis   | after de<br>I Directo<br>d in by t  | Certification: | 3 ☐ Suicide<br>4 ☐ Homicide  | 6 Could n<br>determi     | ned Zoe. Flat  | ce of injury ding, etc. (5  | - At home, far<br>Specify) | rm, stre      | eet, factor                                 | y, office               |                                    |                    | 28f. Location<br>City or To             | (Street and<br>own, State)  | Number or R                              | ural Route Number,                                 |   |
| Hospital  | within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2  | Medical C      | 29a. Certifier<br>(Check only<br>one)  |                          | g Physician: To the<br>Examiner: On the<br>and ma              |                             | amination an               |               |   |                         |                                    |                    |   |                             |  |  |   |
| To#   | Withi<br>To t   | Ž              | 29b. Signature and   |                          | IG   |                             |                            |               |   |                         | e numbe                            |                    |   |                             |  | th, Day, Year)                                     |   |
| . 8 -   |   |                | - T  | JODP                     | -  |                             | (1) 00 11                  | T             |   | J-1 (                   | 152                                | 7                  |   | 400                         | USII                                     | 0,2007   |   |
| 4   | Y   |                | 30. Name and a dre   | TOORIE                   | , mo   | 7503                        | SURR                       | ATT           | s R   | OAD                     | , c                                | LINTO              | ow, m                                   | ARY L                       | AND                                      | 20735  | _ |
| 2   | Sta<br>Regist   | ate<br>rar     | 31. Date filed (Mont   | G1 5 2                   | 007  | Hegistrar's                 | Signature                  | foo           | et s  |                         |                                    |                    |   |                             |  |  |   |

07-06041 Brian Noble Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2007 26170

|   |                                     | - For State   |   | ,  | Certifica                               | te of D  | eath                                       |  |                                     | Reg.                                     |   | 0 0 . 1  |  |
|---|-------------------------------------|---|---|--|---|--|--|--|-------------------------------------|--|---|--|--|
| Physiciai<br>ledical Examin   | 1/                                  | Decedent's Name (Fir  | st, Middle,Last)  | obla   |   |  |  |  | _ N                                 | Date of Death<br>Month [<br>Jugust 6, 21 | Day Year  | L L  | me of Death<br>152 hrs                               |
| legical Examin  |                                     | a. Facility Name (if not  |   | street and number)   |   |  | City, Town, or L                           | ocation of I   |                                     | oguet of E                               | 4c. County of   | Death  |  |
| Joseph  |                                     | Mercy Medical   |   | 17.45-7  | In yrs. last birth                      |  | Baltimore<br>f Under 1 Year                | If Under   | 24Hrs 8                             | Date of Birth                            | (MM/DD/YYYY)  | 9 Birthplac  | ce (State or   |
| Funeral<br>Director   |                                     | 5. Social Security Numb   | 22 1XM  | 7. Age (   | t 6                                     |  | Months Days                                | Hours  | Min.                                | Oct.4                                    |   | Foreign<br>Country   | Md.  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23; injury or other tranmatic event, the Medical Examiner must be not   | To Be Completed by Funeral Director | 10e. Street and Number 2765 11. Marital Status 1 Never Married 3 Widowed 15. Decedent's Educa Elementary/Seconda 17. Father's Name (Firs 19a. Informant's Name/ 20a. Method of Disposi  | Bak  2 Married 4 Divorced If  attion (Specify only  attion (Typelationship (Typelationship)  Cremation 3 Other Specify:  al Service License | 12. Was Decedent E Armed Forces? 1 Yes 2 Yes, Give Year or Dates: 7 highest grade comp College (1-4 or 5-1) Pepe, Print Mot Removal from State | No letted) 16a. C                       | 13. Was E If Yes, 1 Yes, 20ecedent's uring most Part of Disposition or or other 22. Nat Jack | on (Name of central place)  me and Address | Mexican, F specify: on (Give ki DO NOT u  18. Mother's L and Numb  L e r netery, of Facility | ind of work use retired is Name (Fi | rst, Middle, M                           | White, Specify: 16b. Kind of Bus aiden Surname) Der, City or Town 20c. Location | at Country?  American I etc.  Black ainess/indus  Automatical Auto | Code)  216  In, State  MA  216  Approximate Interval |
| Physician<br>Medical<br>Examiner  | Examiner                            | failure. List only of failure. List only of failure. List only of failure list cause (Fina or condition resulting in Sequentially list condition failure cause. Enter Underly (Disease or injury that events resulting in dea | al disease a n death) b tions, clate ng Cause initiated c   | h line.  Narcotic in  Due to (or as a conse  | toxicatic<br>quence of):<br>quence of): |  |  |  |                                     |  |   | E  | Between Onset and<br>Death                           |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | by Physician/Medical Ex             | X UNPENDED  IF FEMALE: 23b. Was decedent pre past 12 months?  1 Yes 2 No  Part II. Other significations   | 9 Unknown   | 23c. If yes, outcom  1 Live birth  4 Pregnant at  9 Unknown  | time of death                           | Feta   | death 3                                    | Ectopic  |                                     | 23e. Did to                              |   | Day  | Year cause of death?  ly 4 ✔ Unknown                 |
| Division of Vital Records, P.O. tal or stending Physician: The law requires that the ras after death.  The Director: After this certificate has been signed by led in by the fumeral director, page 2 should be detact  | Completed t                         |   |   |  |   |  | 26 Place                                   | e of Death   | (Check or                           | 24a. Was<br>autop<br>perfo               | an 24b. sy  | Were autop   | ssy findings available appletion of cause of 2 No    |
| Vital Rec<br>nysician: The I<br>this certificate I  | Be                                  | 25. Was case referred examiner?   | H   | lospital: 1 Inpatie  | nt 2 🗸 ER/C                             | utpatient  |  | Other <sub>4</sub>   |                                     |  | Residence 6   | Other:   |  |
| Division of Vital Rec<br>To the Hospital or Attending Physician: The I<br>within 24 hours after death.<br>To the Funeral Director: After this certificate I<br>completely filled in by the funeral director, page   | Certification: To                   | 1 Yes 2  27. Manner of Death  1 Natural  2 Accident   | No Pending Investigation  | 28a. Date of Inju<br>(Month, Day,Y   | ry 28b.<br>ear) FNd                     | Time of In   | jury 28c. Inju                             | ury at Work Yes 2 X building, et   | No                                  | unk                                      | how injury occur  |  | Route Number, City                                   |
| Division To the Hospital or Attentity within 24 hours after death To the Funeral Director: completely filled in by the  | ertific                             | 4 Homicide  | Could not be determined   | (Specify) fo   | und in ho                               | use  |  |  |                                     | or Town, S<br>1527 <b>Fn</b> s           | State)<br>or St., Ba  | ltimore  | e, MD  |
| he Hosp<br>in 24 ho<br>he Fune<br>pletely f   |                                     | 29a. Certifier 1 Ce<br>(Check only one) 2 M   | ertifying Physicia  | an: To the best of m   | y knowledge, de<br>mination and/or      | eath occurr<br>investigati   | ed at the time, on, in my opinio           | iate and pla<br>n, death od  | ace, and d<br>ccurred at            | lue to the caus<br>the time, date        | se(s) and manne<br>and place, and   | er as stated.<br>due to the o  | :ause(s)   |
| To the within To the comple   | Medical                             | 29b. Signature and titl   | le of certifier   | and manner stated.   |   |  | 29c. Licen                                 | se number  |                                     |  | 29d. Date sign  | ned (Month   |  |
|   |                                     | 30. Name and address  |   | completed cause of c   | ieath (item 23a)                        |  |  |  |                                     | 04001                                    | 32011   |  |  |
|   |                                     | Donna M. Vin  |   | Assistant Medic  | cal Examine                             |  | Penn Stree                                 | t, Baltim  | ore, ME                             | 21201                                    |   |  |  |
| S<br>Regis  | tate<br>trai                        | 4.0   |   | 107 Mag  | w J.                                    | Pos  | all !                                      |  |                                     |  |   |  |  |
| DHMH 17 Rev 1/2   | 2001                                |   | DCME  |  | 0                                       | RIGINA   |  |  |                                     |  |   |  |  |

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|   |                | 1- State of Maryland / Department of Health and Certificate of Death   | Mental Hy                            | /giene                                 | 7 26171  |
|---|----------------|--|--------------------------------------|--|--|
| Dhyoi   | ioion          | 1. Decedent's Name (First, Middle, Last)   | 2. Date of D<br>Month                | eath<br>Day Ye                         | 3. Time of Death                                     |
| ∘Physi<br>/Med  |                | Laura G. O'Connor  | Augus                                | t 14, 2007                             | 11:30 A M  |
| Exam  | niner          | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Dea 112 Sycamore Rd. Linthicum   | th                                   | 4c. County of E                        |  |
| Funera  | al l           | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs  |                                      | Anne Ar                                | unde L Birthplace (State or Foreign                  |
| Directo   |                | 217-52-1408  | Dec. 2                               | ay, Year)                              | Country)<br>laryland                                 |
| pug M   |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |                                      |  | 10d. Inside City Limits                              |
| Maryla<br>f shor  | ō              | Maryland Anne Arundel Linthicum  |                                      |  | 1 ☐ Yes 2 🛣 No                                       |
| r 28a-<br>notif   | Director       | 10e. Street and Number 10f. Zip Code   |                                      | 10g. Citizen of What                   | Country?   |
| th with   | <u>8</u>       | 112 Sycamore Rd. 21090   |                                      | United Sta                             | ates   |
| tems<br>tems  | Funeral        | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Support of Mexican, Pue)  | Specify Yes or N<br>rto Rican, etc.) | o- 14. Race - A<br>Black, W            | merican Indian,<br>/hite, etc.                       |
| filed within 72 hours after death with the Maryland Hygiene.  Hygiene. The "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at  | by Fi          | 1 Never Married 2 Married 1 Yes 2 No   |                                      | Specify:                               | White  |
| 2 hour  |                | 15. Decedent's Education 16a. Decedent's Usual Occupation  |                                      | 16b. Kind of Busine                    |  |
| thin 7:   | Completed      | (Specify only highest grade completed) (Give kind of work done during most of wo life. DO NOT use retired)  HOME and A P   | orking                               |  |  |
| ed will<br>ygien<br>her th  | 5              | 12 Homemaker   |                                      | Own Home                               | <u> </u>   |
| l be fill hall He out   | Be             | Norman T. Tana   | ·                                    | e, Maiden Surname)                     |  |
| 2 should be and Mental is marked or aumatic ever  | 2              | 19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Relationship)   |                                      |  | e Zin Code)  |
| and 2 sealth ar n 27 is   |                | Lawrence J. O'Connor / Son 112 Sycamore Rd., Lin   |                                      |  |  |
| es 1 a of Hear  |                | 20a. Method of Disposition 20b. Place of Disposition (Name of  | ıst 17,                              | 20c. Location - City                   |  |
| Pages<br>ment of h<br>ant: If ite<br>ury or of  |                | 1 Burial 2 Tremation 3 Removal from State 4 Donation 5 Other (Specify)  Baltimore Nat. Cem.  | 2007                                 | Baltimore                              | , Maryland   |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at | ouce.          | 21. Signature of Funda Licepter  K1 K1 and Address of Facility Fu 421 Crain Hwy., S.   | neral H<br>E., Gle                   | ome, P.A.<br>n Burnie,                 | MD 21061   |
| S. Elem   |                | 23a. Part1. It ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.  |                                      |  | Approximate<br>Interval Between                      |
| Physician   | _              | Immediate Cause (Final disease or condition resulting in death)  a. 2006   | Onset and Death                      |  |  |
| /Medica<br>Examine  |                | Due to (or as a consequence of):   | 26 4 / /                             | ^                                      |  |
|   | e e            | if any, leading to immediate Due to (or as a consequence of):  | nor is                               |  |  |
| uted<br>d<br>ansit  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events  c.   |                                      |  |  |
| e exection and an arrial-tr   |                | resulting in death) Last  Due to (or as a consequence of):   |                                      |  |  |
| fficate be executed<br>physician and<br>st the burial-transit   | ledical        | d  |                                      |  |  |
| ) <u>*=</u>   | /Mec           | IF FEMALE: 23c. If yes, outcome pf pregnancy   |                                      |  |  |
| The law requires that the death certification is the has been signed by the attending age 2 should be detached for use as   | Physician/M    | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2540  4 Pregnant at time of death 5 Other (specify)  |                                      | 23d. Date of<br>Month                  | Day Year   |
| t the c   | hysi           | 9 ☐ Unknown  |                                      |  |  |
| res that the de<br>signed by the a  | by P           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |                                      | ~**                                    | e to the cause of death?                             |
| w require<br>been si<br>should I  |                | All my my mease  | 1 🗆                                  | Yes €Z∏No, 3⊑                          | Probably 4 Unknown                                   |
| e law<br>has be   | Completed      |  | 24a. Was                             | opsy prior                             | autopsy findings available to completion of cause of |
|   |                |  | pen<br>1□ Yes                        | formed? death                          |  |
| sician<br>certification   | o Be           | examiner?  | ath (Check only                      |  |  |
| Attending Physician: The rideath. ector: After this certificate his by the funeral director, page   | -              | 27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at  |                                      | sidence 6 Other (5 how injury occurred | Specify)   |
| ath.  | atio           | 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No  |                                      |  |  |
| or Atter<br>ter de<br>virecte   | Certification: | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |                                      | (Street and Number of<br>own, State)   | r Rural Route Number,                                |
| pital of purs af eral D   |                | 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.   | and due to the                       | a causa(a) and manna                   | r on state of  |
| To the Hospital or Attend within 24 hours after death.  To the Funeral Director: 8 completely filled in by the fr   | edical         | 29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one) |                                      |  |  |
| To th<br>Within<br>To th  | ₹              | 29b. Signature and title of certifier 29c. License number  |                                      | 29d. Date signed (M                    | onth, Day, Year)                                     |
|   |                | D8387  |                                      | August 1                               | 4, 2007  |
| 10  |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  James J. Benjamin, M.D., 8109 Ritchie Hwy., Pasadena,  | Maryla                               | nd 21122                               |  |
|   | tate           | 31 Date filed (Month Par Vear) 32 Projector's Signature  |                                      |  |  |
| Regis   | strar          | AUG 1 5 2007 Series & Species  |                                      |  |  |

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

|   |  |  | or Print in Black<br>e of Maryland / De  |  |  |  |   | е.   |  |  |  |
|---|--|--|--|--|--|--|---|--|--|--|--|
|   | 1  | For State  | -  | Certificate of L   |  |  | g. No. 201  | 17 26172   |  |  |  |
| Physicia  | n  | Registrar  Decedent's Name (First, Middle, Last)  TSILYA   |  | OZERYAN  | 2  | Date of Death<br>Month                 | Day Ye  | 3. Time of Death 9:48 p.M  |  |  |  |
| /Medica<br>Examine  | A  | ia. Facility Name (If not institution, give street a.<br>Sinai - Hospital of   | 4.4  |  | imore ut   | y.                                     | 4c. County of I                                   | N/A  |  |  |  |
| Funeral<br>Director   |  | 5. Social Security Number 6. Sex 1 1 M 2 M   | 7. Age (In yrs. last birth)<br>88 Yr   | Months   Davs  | Hours Min.   | Date of Birth (Month, Day, 7 / 14 / 19 | Year)   | Birthplace (State or Foreign<br>Country)<br>THUANIA                                      |  |  |  |
| n the Maryland<br>rr 28a-f show<br>s notified at  |  | Jsual Residence of Decedent  10a. State 10b. County  MD N/A  | 10c. City, Town of BALTI   |  |  |  |   | 10d. Inside City Limits 1  |  |  |  |
| ₹ 2 a   | ਰ ∣  | 10e. Street and Number<br>6962 MILBROOK PARK   | DRIVE # 1-A  | 10f. Zip Code<br>21215   |  | 10                                     | Og. Citizen of What                               | at Country?  |  |  |  |
| after<br>or ite<br>mine   | by Funeral   | 11. Marital Status 12. Warried 1 □ Never Married 2 □ Married 1 □ If Y  |  | 13. Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 No  | ispanic Origin? (Spec<br>an, Mexican, Puerto R<br><i>Sp</i> ec <i>ify:</i> | ify Yes or No-<br>ican, etc.)          |   | American Indian,<br>White, etc.<br>WHITE   |  |  |  |
| in 72 hou<br>n "natura<br>Aedical E   | Completed  | 15. Decedent's Education (Specify only highest grade comp  | leted) ()  | Decedent's Usual Occup<br>Give kind of work done of<br>life. DO NOT use retired<br>R DRESSER   | during most of working   |  | 16b. Kind of Busin                                |  |  |  |  |
| be fill Hall Hall Hall of oth   | To Be Co   | 17. Father's Name (First, Middle, Last) YEFIM  | KRAVIT   | -Z   | 18. Mother's Name (  |  |   | KRAVITZ  |  |  |  |
| nd 2 shou<br>alth and M<br>27 is mar<br>r traumat   |  | 19a. Informant's Name/Relationship (Type. Pri  | 4  | Mailing Address (Street<br>119 DOE MEAI<br>Disposition (Name of<br>the crematory or other place)   | DOW DRIVE  | - OWING                                | S MILLS,  | , MD 21117   |  |  |  |
| 00  |  | 20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)                                       | 4/2007   | 20c. Location - Ci<br>REISTERS   | STOWN, MD<br>ROS., INC.  |  |   |  |  |  |  |
| permit. Pag<br>Department<br>Important: I<br>any injury o<br>once.  |  | 21. Signature of Funeral Service Licensee  |  |  | STERSTOWN  | ROAD -                                 | PIKESVII  | LE, MD 21208   |  |  |  |
| Physician   |  | 23a. Part1. Enter the disease or complication shock or heart failure. List only one cau Immediate Cause (Final disease or condition a. | Cardio Respis  | ratory an  |  | respiratory arr                        | est,  | Interval Between<br>Onset and Death  |  |  |  |
| executed hard wand ial-transit  | Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events      | Due to (or as a consequence of   | mic stok   |  | ive.)                                  |   | 1-day.<br>2-days.  |  |  |  |
| The law requires that the death certificate be eate has been signed by the attending physician bage 2 should be detached for use as the burit                   | Physician/Medical E  |  |  |  |  |  |   |  |  |  |  |
| ires that the<br>signed by the  | by   | 9 Unknown  Part II. Other significant conditions contribut  Rheumali: Int disease  |  |  | 0  | 23e, Did to                            |   | oute to the cause of death?<br>3 ☐ Probably 4 ☐ Unknown                                  |  |  |  |
| The law requirate has been sipage 2 should I  | Completed  | Obstraction,   |  |  |  | 24a. Was autop<br>perfo                | rmed? pr  | fere autopsy findings available<br>rior to completion of cause of<br>eath?<br>□Yes 2 □No |  |  |  |
|   | To Be  | 25. Was case referred to medical examiner?  1 Yes 2 No Hospit  27. Manner of Death 28  | a. Date of Injury 28b. T   | Time of 28c. Inju  |  | me 5 ☐ Resid                           | <i>ne)</i><br>dence 6 ⊟Othe<br>now injury occurre |  |  |  |  |
| the Hospital or Attending Physician:<br>hin 24 hours after death.<br>the Funeral Director: After this certifical<br>mpletely filled in by the funeral director, | 27. Manual 5   Pending investigation 2   Accident 3   Sulcide 4   Homicide   Homicide   Signature   Si |  |  |  |  |  |   |  |  |  |  |
| To the Hospital or Attend within 24 hours after death To the Funeral Director:  | Medical Ce   | (Check only 2 Medical Examiner:  | n: To the best of my knowledge<br>On the basis of examination an<br>and manner stated.   | e, death occurred at the d/or investigation, in my   | time, date and place,<br>opinion, death occur                              | and due to the<br>red at the time,     | cause(s) and mai<br>date and place, a             | nner as stated.<br>and due to the cause(s)   |  |  |  |
| To the within To the compl  | Me   | 29b. Signature and title of certifier  | I. MD  |  | S-000  |  |   | (Month, Day, Year)   |  |  |  |
| 17  | T.   | 30. Name and a fires of person of comple   | , MD, Sina   |  | es-000<br>al of Bal  | umor                                   | e_  | //20   |  |  |  |
| Sta<br>Regist   |  | 31. Date filed (Month, Day, Year)  | 32. Begistrar's Signature  | Sparke   |  |  |   |  |  |  |  |
| DUMU 17 Pay 1/2   | 2001   | AUG 1 5 ZUU/   | Jacob Contraction of the Contrac | of the same of the |  |  |   |  |  |  |  |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 28 2007 4:00 0 ames /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number).

5 nai Hospital of Examiner Birthplace (State or Foreign Country), 5. Social Security Number **Funeral** Months 230-20-438 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10b. County 28a-f show at Saltimore 1 Yes 2 □ No Mary land ortant; If item 27 is marked other than "natural", or items 23a or 28a-f st Injury or other traumatic event, the Medical Examiner must be notified Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 No ff 44 1 Yes 1 ☐ Never Married 2 ☐ Married Black If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No 3altimore, Maryland 21215-0036 þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Mem. Hosp. Sienz Union The Grade 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be UNKNOWN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) uepartment of Health ar Important; if item 27 Is any Injury or any Injur Bernadire ltimore 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 □ Cremation 3 □ Removal from State 6/07 Juings Mills, MIS 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee MLD 21215 Rusterstown Laror 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 3 days /Medical Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an this certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes funeral Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. ours after death. neral Director: A filled in by the fu investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 07/28/2007

State Registrar 31. Date filed (A

DHMH 17 Rev 1/2001

Hospital of Bullimore

ed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  |                           | 1 - For State Registrar   | State of Maryland /                                    |              | rtment of H                           |   |                   | giene 🚄 U U<br>Reg. No. | 1 601/4   |
|--|---------------------------|---|--|--------------|---------------------------------------|---|-------------------|-------------------------|---|
|  |                           | Decedent's Name (First, Middle, Last)   |  |              |                                       |   | 2. Date of De     |                         | 3. Time of Death  |
| Physi  | cian                      | Joseph E. Pier  |  |              |                                       |   | Month             | 14, 2007                | 1:45 A. M   |
| /Med   |                           | Joseph E. Ples  4a. Facility Name (If not institution, give str   |  |              | 4b. City, Town, o                     | r Location of Death                       |                   | 4c. County of I         |   |
| Exam   | iner                      | St. Mary's Hospital   |  |              | Leonard                               |   |                   | St.                     | Mary's  |
|  |                           | 5. Social Security Number 6. Sex  | 7. Age (In yrs. last                                   | birthday)    | If Under 1 Year                       | If Under 24 Hrs.                          | 8. Date of Birt   |                         | Birthplace (State or Foreign Country)                         |
| Funera Directo   | _                         |   | 1 2□F 72   | Yrs.         | Months Days                           | Hours Min.                                | (Month, Da        | y, Year)<br>1935 Wa     | ashington, D.C.   |
|  | ۸.                        | Usual Residence of Decedent   | 12   |              |                                       | J   | Joury 23          | 7 1500 1110             |   |
| iand<br>ow   |                           | 10a. State 10b. County  | 10c. City, To  | own or Loc   | ation                                 |   |                   |                         | 10d. Inside City Limits                                       |
| Mary<br>f sh   | ğ                         | Maryland Anne Arui  | odol Tobo  | essup        |                                       |   |                   |                         | 1 ☐ Yes 2≿⊡tNo  |
| the 28s  | Director                  | 10e. Street and Number  | ide1 b   | SBSGP        | 10f. Zip Code                         |   |                   | 10g. Citizen of Wha     | it Country?   |
| C Z1Z13-UU36<br>filed within 72 hours after death with the Maryland<br>Hygiene.<br>byther than "natural", or items 23a or 28a-f show<br>ent, the Medical Ezat-a et must be motified at   |                           | 1833 Montevideo Roa   | ьd   |              | 20794                                 |   |                   | United                  | States  |
| eath   | Funeral                   |   | . Was Decedent Ever in U.S.                            | 13. W        |                                       | lispanic Origin? (S<br>an, Mexican, Puerl | pecify Yes or No  | - 14. Race -            | American Indian,  |
| ter d  | ٦                         | 1 □ Never Married 2 ☑ Married   | Armed Forces?<br>1 ☐ Yes 2√√No                         |              |                                       |   | o Rican, etc.)    |                         | White, etc.   |
| rs af  | þ                         |   | ff Yes, Give<br>Year or Dates:                         | 1            | ☐ Yes 2 1 No                          | Specify:                                  |                   | Specify:                | White   |
| Po Po  |                           |   | tion 16  | 6a. Decede   | ent's Usual Occup                     | ation                                     |                   | 16b. Kind of Busin      | ess/Industry  |
| D 72 n 72 n 100  | Completed                 | (Specify only highest grade   | completed)   | (Give k      | ind of work done<br>O NOT use retired | during most of wor<br>d)                  | king              |                         |   |
| With N   | Ĕ                         | Elementary/Secondary (0-12)   | Colfege (1-4or 5+)                                     | Mason        |                                       |   |                   | Construct               | cion  |
| illed withi<br>i filed withi<br>i Hygiene.<br>other ther   |                           |   |  | labon        |                                       | 18. Mother's Nan                          | ne (First, Middle | Maiden Sumame)          |   |
| De f<br>be f<br>ntat h<br>ed of  | 98                        |   |  |              |                                       | Mary My                                   | ers               |                         |   |
| Y Sould hould hark hearth  | ٩                         | 19a. Informant's Name/Relationship (Type  | Origit) 1  | Oh Mailine   | Address (Street                       |   |                   | er, City or Town, Sta   | ate. Zip Code)  |
| Maryiand 21213-UU36 Id 2 should be liled within 72 hours all th and Mental Hygiene. 27 is marked other than "natural", or traumatic event. I're Medical Exatu- traumatic event.  |                           | Joseph C. Pierce /  |  |              | Montevio                              |   | Jessup,           |                         |   |
| - 50 - 6   |                           | A   |  |              | ition (Name of                        |   |                   | 20c. Location - Cit     | v or Town State   |
| Ore<br>of H<br>Hite  |                           | 20a. Method of Disposition 1 √2 Burial 2 ☐ Cremation 3 ☐ Re   | come   | etery, crem  | atory or other pla                    |   |                   |                         |   |
| Pag<br>Tient<br>Innt: I  |                           | '4 Donation 5 Other (Specify)   | Glen   | HAve         | n Mem. F                              | k. 20                                     | 07                | Glen Burn               | nie, MD   |
| Baltimore, permit. Pages 1 ar Department of Hea important: if Item; any injury or other  | ğ                         | 21. Signature of Funeral Service Licenses   | 1  | K1           | Name and Addre                        | ss of Facility                            | neral He          | me P.A.<br>Burnie, MI   | 21061   |
| m 9972   | a                         | pu Labo   | Ng   |              |                                       |   |                   |                         |   |
| 10.00  |                           | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one   | ations that caused the death. It cause on each line.   | Do not ente  | r the mode of dyli                    | ng, such as cardiad                       | or respiratory a  | rrest,                  | Approximate finterval Between                                 |
| Physicia   | n                         | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. Caldiores protein quart |  |              |                                       |   |                   |                         |   |
| /Medica  |                           | disease or condition resulting in death)  | ce of). /  |              |                                       |   |                   |                         |   |
| Examine  | er :                      |   | Prostate Co  | en Cea       | . Eme                                 | tentario                                  | ,                 |                         |   |
| 7 15 to  | 9                         | Sequeritally list conditions,   |  |              |                                       |   |                   |                         |   |
| betr   | 1.5                       | Cause (Disease or injury  |  |              |                                       |   |                   |                         |   |
| sxecu<br>and<br>al-tra   | Examine                   | that initiated events c. resulting in death) Last   | Due to (or as a consequen                              | ce of):      |                                       |   |                   |                         |   |
| (8760, cate be executed physician and the burial-transit   | dical                     |   |  |              |                                       |   |                   |                         |   |
| phys   |                           |   |  |              |                                       |   |                   |                         |   |
| Box 6 leath certific attending p   | /Me                       | IF FEMALE: 23   | c. If yes, outcome of pregnancy                        | ,            |                                       |   |                   | 23d. Date of            | of delivery   |
| Box<br>eath cert<br>attendin   | an                        | 23b. Was decedent pregnant in the past 12 months?   | 1 Live birth 2 Fetal de<br>4 Pregnant at time of death | ath 3        | Ectopic pregnance Other (specify) _   | у   |                   | Month                   | , , ,   |
| P.O.   | Sici                      | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9 Unknown  | . 30         | Other (apochy) _                      |   |                   |                         |   |
| P.O. that the de ed by the detached  | Completed by Physician/Me | Part II. Other significant conditions cont  | shuting to death but not resulting                     | a in the un  | deriving cause or                     | ven in Part I                             | 23e. Did          | tobacco use contribi    | ute to the cause of death?                                    |
| ds, F<br>uires tha<br>signed<br>d be del   | ۾                         | Congostine book   | + Railure.   | 9            | son, mg sacco g                       |   |                   |                         | Probably 4 Punknown   |
| cord w requir  | Ped                       | College I West  | 1 19110  |              |                                       |   | -                 |                         |   |
| as be  | D e                       | Hypertension  |  |              |                                       |   | 24a. Was          | psy pric                | re autopsy findings available<br>or to completion of cause of |
| The The sage   | 8                         | ,   |  |              |                                       |   | perf              | ormed? dea              | ath?<br>]Yes 2□ No  |
| E E E E E E E E E E E E E E E E E E E  | a                         | 25. Was case referred to medical  |  |              |                                       | 26. Place of De                           | ath (Check only   | one)                    |   |
| Division of Vital Records, P.O. Box 6i to a variation of Vital Records, P.O. Box 6i to Attending Physician: The law requires that the death certificate death.  **Director: After this certificate has been signed by the attending provin by the funeral director, page 2 should be detached for use as | ToB                       |   | spital: 1 Inpatient 2 ER                               | /Outpatien   | 3 DOA Ot                              | her: 4 Nursing h                          | dome 5 ☐ Res      | idence 6 Other          | (Specify)   |
| P P P  |                           | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year) 28            | b. Time of   | 28c. Inju                             | ry at                                     | 28d. Describe     | how injury occurred     |   |
| On Beling  | 5                         | 1 ■ Matural 5 Pending 2 Accident investigation  | (MOTH, Day 18at)                                       | Infury       |                                       | Yes 2 No                                  |                   |                         |   |
| Viter dea  | 1                         | 3 Suicide 6 Could not be determined   | 28e. Place of fnjury - At home                         | , farm, stre | et, factory, office                   |   | 28f. Location     | Street and Number       | or Rural Route Number,  |
| Oiv<br>after<br>Dira   | Certification:            | 4 Homicide  | building, etc. (Specify)                               |              |                                       |   | City or 10        | wn, State)              |   |
| Division of Vital Rec<br>To the Hospital or Attending Physician: The law<br>within 24 hours after death.<br>To the Funeral Director: After this certificate has<br>completely filled in by the funeral director, page 2  |                           |   | cian: To the best of my knowle                         | dge, death   | occurred at the t                     | me, date and place                        | e, and due to the | cause(s) and mann       | er as stated.   |
| 24 h<br>Fun  | de cipa                   | (Check only 2 Medical Examin  | er: On the basis of examination and manner stated.     | and/or inv   | restigation, in my                    | opinion, death occ                        | urred at the time | date and place, and     | d due to the cause(s)   |
| thin<br>thin<br>the  | M                         | 29b. Signature and I/Fe of certifier  | 1.17 /   |              | 29c. Licen                            | se number                                 |                   | 29d. Date signed (      | Month, Day, Year)   |
| 8 7 8 7  |                           | Mem Kd P  | Thole  |              | Do                                    | 06097                                     | 3                 | 08/14/3                 | 2007  |
|  |                           | 17/00/11/1  |  | 2-1/7        |                                       | ,   |                   | · ————                  |   |
| 8  |                           | 30. Name and address of person who con  |  |              |                                       |   | . 7:              | WD 000                  | EO  |
|  |                           | Mehrdad -Akhlagi,<br>31. Date filed (Month, Day, Year)  | M. D. 25500 P  |              | Lookout                               | Rd. Lec                                   | nardtow           | n, MD 206               | 50  |
|  | State<br>istrar           | NIIO 1 = 20   | 07 Pagistral's digitation                              | 1 1          | maria                                 |   |                   |                         |   |

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician /Medical Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

12 State

|   | 1 - State<br>Registrar  | ate of Marylar  | -   | tificate of L                           |                                | -                                   | Reg. No.   | 2007  | 25175  |  |
|---|---|---|---|---|--------------------------------|-------------------------------------|--|---|--|--|
|   | 1. Decedent's Name (First, Middle, Last)  |   |   | 2. Date<br>Mont                         |                                |                                     |  | Year  | 3. Time of Death   |  |
| an<br>al -                              | MARION  |   | PO  | NICKI                                   |                                | AUGUST                              | 7,   | 2007  | 9:30 P.M.  |  |
| er                                      | 4a. Facility Name (If not institution, give street  | and number)   |   | 4b. City, Town, or                      |                                |                                     | 4c. (  | County of Death                                     |  |  |
| a                                       | FOREST HILL HEALTH &  |   |   |   | REST HILI                      |                                     |  | HARFOI  |  |  |
|   | 5. Social Security Number  6. Sex 1 M 2 Usual Residence of Decedent   | 7. Age (In yrs. 82  | Yrs.  | If Under 1 Year Months Days             | If Under 24 Hrs.<br>Hours Min. | 8. Date of Bir (Month, Da 5-15-1)   | y, Year)   | 9. Birthp<br>Coul<br>Mary                           | place (State or Foreign<br>ntry)<br>Land                   |  |
|   | 10a. State 10b. County  | 10c. Cit  | ty, Town or Loc   | ation                                   |                                |                                     |  |   | 10d. Inside City Limits                                    |  |
| ļo                                      | Maryland Harford  | Be1   | Air   |   |                                |                                     |  |   | 1 ☐Yes 2 ☐ No  |  |
| irec                                    | 10e. Street and Number  |   |   |   |                                |                                     |  | zen of What Coul                                    | ntry?  |  |
| al D                                    | 304 Hemingway Dr.   |   | 21014   |   |                                |                                     |  | S.A.  |  |  |
| ıneı                                    | 11. Marital Status 12. W. Ar  | as Decedent Ever in U<br>med Forces?  | in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) |   |                                |                                     |  | <ol> <li>Race - Americ<br/>Black, White,</li> </ol> |  |  |
| To Be Completed by Funeral Director     | 1 ☐ Never Married 2 ☐ Married 1 ☐ If 1 ☐ 3 ☐ Widowed 4 ☑ Divorced Ye  | □Yes 2□No<br>Yes, Give X<br>ear or Dates:   | 1 ☐ Yes 2 No Specify: Specify:  |   |                                |                                     |  |   | nite   |  |
| etec                                    | 15. Decedent's Education (Specify only highest grade com  |   | 16a. Decedent's Usual Occupation 16b. Kind of Busin   |   |                                |                                     |  |   | dustry   |  |
| mp                                      |   | ollege (1-4or 5+)   | (Give kind of work done during most of working life. DO NOT use retired)  Seamstress  Clothing Manufa                   |   |                                |                                     |  |   | ufacturer  |  |
| ပို                                     | 17. Father's Name (First, Middle, Last)   |   | J   | Ĭ                                       | 18. Mother's Nam               |                                     | lle, Maiden Surname)   |   |  |  |
| To B                                    | Randall Dat   | ney   |   | Josephine Whitles                       |                                |                                     |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type. Pr<br>Carl Ponicki  | int)<br>Son   |   | g Address <i>(Street a</i><br>Hemingway |                                |                                     |  | ' = ' '   | code)  |  |
|   | 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  St. Stanislaus  20c. Location - City or Town, State  8-11-07  Baltimore, Maryland |   |   |   |                                |                                     |  |   |  |  |
|   | 21. Signature of Funeral Service Licensee  Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Rd. Bel Air, Md. 21014   |   |   |   |                                |                                     |  |   |  |  |
|   | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between                        |   |   |   |                                |                                     |  |   |  |  |
|   | Immediate Cause (Final disease or condition resulting in death)  Onset and Death  2 Well()  |   |   |   |                                |                                     |  |   |  |  |
|   | Sequentially list conditions b. My Caucaca Warhon   |   |   |   |                                |                                     |  |   |  |  |
| amine                                   | cause. Enter Underlying Cause (Disease or injury that initiated events  |   |   |   |                                |                                     |  |   |  |  |
| cal Ex                                  | resulting in death) Last  Due to (or as a consequence of):  |   |   |   |                                |                                     |  |   |  |  |
| edi                                     |   |   |   |   |                                |                                     |  |   |  |  |
| Completed by Physician/Medical Examiner | in the past 12 months?  | yes, outcome pf pregn<br>□Live birth 2 □ Feta<br>□Pregnant at time of a<br>□Unknown | etal death 3 ☐ Ectopic pregnancy  |   |                                |                                     |  | 23d. Date of delivery<br>Month Day Year             |  |  |
| y Pr                                    | Part II. Other significant conditions contribut   | ing to death but not res  | sulting in the un   | derlying cause give                     | en in Part I.                  | 23e. Did t                          | d tobacco use contribute to the cause of death?                        |   |  |  |
| ed b                                    |   |   |   |   |                                | 1 🗆                                 | Yes 2 3 Probably 4 Unknown   |   |  |  |
| omplet                                  |   |   |   |   |                                | 24a. Was<br>auto<br>perfo<br>1□ Yes |  | 24b. Were auto<br>prior to co<br>death?<br>1 □ Yes  | opsy findings available<br>ompletion of cause of<br>2 ☐ No |  |
| Be C                                    | 25. Was case referred to medical  |   |   |   | 26. Place of Dea               |                                     |  |   |  |  |
| To E                                    | examiner? 1 Yes 2 No Hospita  | <sup>al:</sup> 1 ☐ Inpatient 2 ☐  | ] ER/Outpatient   | 3 DOA Othe                              | er: 4 Nursing H                | ome 5 ☐ Resi                        | dence 6  | 6 □Other (Speci                                     | ify)   |  |
| tion:                                   | 27. Many r of Death  1. Natural 5 Pending investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  M 28c. Injury at Work?  1 Yes 2 No  |   |   |   |                                |                                     |  |   |  |  |
| ertifica                                | - Classes & Classid and he  | e. Place of injury - At h<br>building, etc. (Speci                                  | uce of injury - At home, farm, street, factory, office 28f. Locati City o   |   |                                | 28f. Location (<br>City or To       | cation (Street and Number or Rural Route Number,<br>ty or Town, State) |   |  |  |
| Medical Certification: To               | 29a. Certifier (Check only one)  CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Check only one)  Check only one)  Check only one)                              |   |   |   |                                |                                     |  |   |  |  |
| Me                                      | 29b. Signature and title of certifier   | 7   |   | 29c. Licenso                            | number                         |                                     | 29d. Date  | e signed (Month,                                    | Day, Year)   |  |
|   | 30. Name and address of person who complet DR. NESKEEN KURTOM -   |   |   |   | /E - REI                       | ATR. MD                             | 210  | 14  | (  |  |
| te                                      | 31. Date filed (Month, Day, Year)   | 32. Registrar's Sign  |   | JANE DEL                                |                                |                                     |  |   |  |  |
| ar                                      | AUG 1 5 200   | AL.   |   | BALL                                    |                                |                                     |  |   |  |  |

Registrar

07-06175 Will

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| liam Parker, J   | 1              | State of Maryland / Department of Certificate of State  |  | Reg. N                            |  | 77 9:                                |  |  |  |  |
|--|----------------|---|--|-----------------------------------|--|--------------------------------------|--|--|--|--|
| Physicia   | n/             | Registrar<br>1. Decedent's Name (First, Middle,Last)  |  | 2. Date of Death<br>Month Da      | av Year  | 3. Time of Death 4                   |  |  |  |  |
| dical Examir   |                | William M. Parker Jr.  4a. Facility Name (if not institution, give street and number)   | 4b. City, Town, or Location of Death   | August 11, 20                     | 4c. County of Death                            |                                      |  |  |  |  |
|  |                | 511 E. 43rd Street  | Daitilliole  |                                   |  |                                      |  |  |  |  |
| Funeral<br>Director  |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 17-52-7736 1  | If Under 1 Year If Under 24Hrs.  Months Days Hours Min.  |                                   | MM/DD/YYYY) 9. Birthp<br>Foreign<br>Coun       |                                      |  |  |  |  |
| w any  | L              | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo   |  |                                   |  | 10d. Inside City Limits 1 X Yes 2 No |  |  |  |  |
| daryland<br>28a-f show<br>1 at once.   | 핡              | 10e. Street and Number  | timore<br>10f. Zip Code  | 10g.                              | Citizen of What Countr                         | ry?                                  |  |  |  |  |
| or 28;   | Director       | 511 E 43rd Street   | 21212  | 127                               | USA  |                                      |  |  |  |  |
| , MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland end 21 is marked office office whan "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once  | uneral         | 1 Never Married 2 Married Armed Forces? 1 X Yes 2 No  | Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto   | pecify Yes or No-<br>Rican, etc.) | 14. Race - America White, etc.  Specify: Blace |                                      |  |  |  |  |
| s after<br>ral", c   | by F           | or Dates:   | Yes 2 X No specify: dent's Usual Occupation (Give kind of  |                                   | 6b. Kind of Business/In                        |                                      |  |  |  |  |
| 11215-0036  (1 be filed within 72 hours after Actual Hygiene anrived other than "natural", event, the Medical Examiner   | Completed by   | College (1-4 or 5+)   | g most of working life. DO NOT use ret<br>e Care Provide:  | r                                 | State of                                       | MD                                   |  |  |  |  |
| 5-0036<br>iled within 7.<br>Hygiene<br>3 other than  | 녌              | 17. Father's Name (First, Middle, Last)   | 18.Mother's Name   | e (First, Middle, Mai             | iden Surname)                                  |                                      |  |  |  |  |
| 21215-00;<br>buld be filed with<br>I Mental Hygiene<br>i marked other ti<br>ie event, the Men  | Be             | Marion W. Parker Sr.  | COS ailing Address (Street and Number or   | Sey O. M                          | loore  | Zip Code)                            |  |  |  |  |
| ire, MD 21215-0036 s: 1 and 2 should be filed within 72 of Health and Mental Hygiera If riem 27 is marked other than her traumatic event, the Medical  | 의              | 19a. Informatics Hamor total action (1) per   |  | 4                                 |  |                                      |  |  |  |  |
| ore, MI<br>es I and 2<br>of Health is<br>If item 27  | -              | Zua. Metrod of Disposition  | 4 Walkern Ave  | Date 2                            | 20c. Location - City or T                      | Fown, State                          |  |  |  |  |
| of H<br>If i   |                | Bayyio  | w Crematory 8/   | /15/07                            | Baltimore                                      | e MD                                 |  |  |  |  |
|  |                | 4 Doparton 5) Other Specify:  21. Signature of the rail Service in ee   | F - 100 -  |                                   | Ave. Bal                                       |                                      |  |  |  |  |
| Ealt<br>permit.<br>Departi<br>Import   |                | Caled fly Camby 1.  | Connolly Funers  | I Homo                            | of Fecov                                       | 21221<br>Approximate Interval        |  |  |  |  |
| Physician  |                | 23a. Pal I. Enter the disease, or red plications that caused the death. Do not enfailure. List only one cause of each line.       | ter the mode of dying, such as calculac  | · ·                               | t, shook, of hour                              | Between Onset and<br>Death           |  |  |  |  |
| 'Medical<br>kaminer  |                | Immediate Cause (Final disease or condition resulting in death)  a. Diabetic ketoacidosis  Due to (or as a consequence of):       |  |                                   |  |                                      |  |  |  |  |
|  | ier            | Sequentially list conditions,  if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):   |  |                                   |  |                                      |  |  |  |  |
|  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of): |  |                                   |  |                                      |  |  |  |  |
| ecuted<br>and<br>transit   |                |   |  |                                   |  |                                      |  |  |  |  |
| 30,<br>re be exect<br>sysician an  | Medical        | X UNPENDED #2527, perME, g871, 9/   | 20/07 TT   |                                   |  |                                      |  |  |  |  |
| 68760,<br>certificate be<br>rding physic<br>se as the bur  | /Mec           | IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy  | Fetal death 3 Ectopic preg   | inancy                            | 23d. Date of delivery  Month                   | y<br>Day Year                        |  |  |  |  |
| certification ce | cian           | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death 5                                   | Other (Specify)  |                                   |  |                                      |  |  |  |  |
| Box 6876 re death certificate the attending phy hed for use as the   | Physician/N    | 1 Yes 2 No 9 Unknown g Unknown  |  | 220 Did tok                       | pacco use contribute to                        | the cause of death?                  |  |  |  |  |
| P.O. Es that the digned by the detached  | 1 1            |   | the underlying cause given in Part I.  |                                   | 2 ✓ No 3 Prot                                  |                                      |  |  |  |  |
| ords, P.O. w requires that as been signed b should be deta   | ed b           |   |  | 24a. Was a                        | an 1 24b. Were au                              | utopsy findings available            |  |  |  |  |
| cord<br>aw req<br>as bee<br>2 shou   | 를<br>  를       |   |  | autops<br>perforr                 | med? death?                                    | completion of cause of               |  |  |  |  |
| Vital Reconysician: The law this certificate has I director, page 2 s  | Completed      |   | 26.Place of Death (Chec  | 1 ✓ Yes 2                         | 2 No 1 Y                                       | es 2 No                              |  |  |  |  |
| cian:  | Be             | 25. Was case referred to medical  | Other  |                                   | Residence 6 🗸 Othe                             | er: Scene                            |  |  |  |  |
| of Vi<br>Physi<br>er this  | 은              | 1 Yes 2 No 28a. Date of Injury 28b. Tim   | ne of Injury 28c. Injury at Work?  | 28d. Describe h                   | now injury occurred                            |                                      |  |  |  |  |
| on of or of or of or of or of or of or   | ion            | 1 X Natural 5 Pending (Month, Day,Year)   | 1 Yes 2 No   |                                   |  |                                      |  |  |  |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and commeledy filled in white finneral director, page 2 should be detached for use as the builal - transi  | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  |  | or Town, St                       | itate)   | tural Route Number, City             |  |  |  |  |
| the Hospi<br>thin 24 hou<br>the Funer  | Medical C      |   | 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) |                                   |  |                                      |  |  |  |  |
| F 18 5 8   | Z e            | 290. Signature and title of certifier   | 29c. License number O.C.M.E.   |                                   | 29d. Date signed (Mo                           | _                                    |  |  |  |  |
|  |                | Morgore me Uncle  | O.C.IVI,E.   |                                   |  |                                      |  |  |  |  |
|  |                | 30. Name and address of person who completed cause of death (Item 23a)  Margarita Korell MD. Assistant Medical Examiner 1         | 11 Penn Street, Baltimore, M   | ID 21201                          |  |                                      |  |  |  |  |
|  | State          | 5110 T - 4000   Mar.   17 (2)   | Carles   |                                   |  |                                      |  |  |  |  |
| Regi   |                | 0.01  | GINAL  |                                   | OCME   |                                      |  |  |  |  |
| DHMH 17 Rev 1  | 12001          | , OKK   |  |                                   |  |                                      |  |  |  |  |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** b City, Town, or Location of Death /Medical Facility Name (If not institution, give street and number) 4c. County of Death Examiner Social Security Number 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, **Funeral** Days 100 M 2□F Months Hours Min. Yrs Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahow the Medical Exacilment the notified at Be Completed by Funeral Director 1 Yes 2 No mor 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 0 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 01 or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Pages 1 and 2 should be 2 19a. Informant's Name/Relationship (Type, Print) laughter 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) Health a Department of Healt Important: If item 2: any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) em eteri 21. Signature of Funeral Service Licensee 22 Name and Address of Facility tome 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or or Attending Physician: The law requires that the death certificate be executed Division of Vital Records. P.O. Box 68760. Be Completed by Physician/Medical use as the ettending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery within 24 hours after death. To the Funeral Director: After this certificete hes been signed by the atter completely filled in by the funeral director, page 2 should be detached for i 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one Hospital Other: 1 ☐ Yes 2 🗹 No ٩ 1 Unpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural Certification: 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

31. Date filed (Month Day Year) -State Registrar

30. Name and address of person who completed cause of death ( m 23 ) (Type, Print)

32. Registr r's Signature

MD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician 007 /Medical Examiner Town, or Location of Death 4c. County of Death Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Months 1 □ M 2 □ F Hours Director aryland death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits must be notified at 1 **Z**es 2 ☐ No Director timore 10e Street and Number 10g. Citizen of What Country? 23a or Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ 3 Widowed 4 Divorced "natural", Completed or than "natur the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 7 is marked other traumatic event, the 17 Father's Name (First, Middle, Last) Be Department of Health and Mental I Important: if item 27 is marked of any Injury or other traumatic evenonce. ပ Informant's Name/Relationship (Type. Print) day 9b. Mailing Address (Street and Number or Rural Route N ber, City or Town, State, Zip Code) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician nontres /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 1 2 Yes 2 2 No 23d. Date of delivery 3 □Ectopic pregnancy ō Month Year Day 5 Other (specify) signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1/∆ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No cate has page 2 s autopsy 1□ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NWS Plu Medical Certification: To 1 ☐ Yes 20 No 1 ☐ Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

State Registrar AADUN J. CHAN LES MD (6701 N
31. Date filed (Month, Day, Year) 32. Repistrar's Signature

32. Registrar's Signature

Sperte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician POWERS 12:45PM August Oleven 2001 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE
If Under 1 Year If Under 24 Hrs. N/A HARBOR HOSPITAL 8. Date of Birth (Month, Day, Year) August 12,1923 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 ☐ F Illinois 350-12-9510 83 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at Anne Arundel Glen Burnie Maryland 1 ☐ Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number death with 6427 Centennial Circle Apt. 21061 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after on the Health and Mental Hygiene.
nt: If item 27 Is marked other than "natural", or iten 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Monitor Steel Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Powers Unkown Unkown ဥ or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2106119a. Informant's Name/Relationship (Type. Print) Department of Health at Important: If item 27 Is any injury or other trau once. 6427 Centennial Circle Apt. A, Glen Burnie, Maryland Marjorie S. Powers 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 08-13-07 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 237 East Patapsco Ave. Baltimore, Mary 1 and implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

100 Ave. Baltimore, Mary 1 and implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. ediate Cause (Final OCARDI Physician isease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day for in the past 12 months? 1 ☐ Yes 2 ANo 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign be ( 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an s certificate has t irector, page 2 s autopsy performed? Yes 2**X** No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After to completely filled in by the funeral Injury 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

514

State 31. Date filed (Month, Day, Year)
Registrar ALIC 1 5 2

XIAO GUANG SUN, 3 ord (Month, Day, Year) B2. Registrar's Signature AUG 1 5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 SUN, 3001 SOUTH HANOVER ST. BALTIMORE, MARYLAND
22. Registrar's Signature

ΜD

RES 000

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|             |  |                   | For<br>State<br>Registrar   | State of M   | aryland / Dep<br><i>Ce</i> | artment of F<br>rtificate of                              |   |   | giene<br>Reg. No.2 () () ()   | 7 26180                                 |  |
|-------------|--|-------------------|---|--|----------------------------|---|---|---|---|---|--|
| 26          | Physici<br>/Medi   |                   | 1. Decedent's Name (First, Middle, Gipsie Lee   |  |                            | 2. Date of Dea<br>Month<br>August                         | 12, 200°  | 3. Time of Death<br>12:53am м   |   |   |  |
|             | Examir   |                   | 4a. Facility Name (If not institution, g  |  |                            |   | r Location of Death                                     |   | 4c. County of D   |   |  |
| X* :        | <u> </u>   | £                 | 6703 White Roc  5. Social Security Number 6   |  | je (In yrs. last birthday  | S:  | ykesville<br>  If Under 24 Hrs.                         |   | Carı  | Coll Birthplace (State or Foreign       |  |
|             | Funeral<br>Director  |                   | 233-52-5374   | 1 M 2 D F  | 72 Yrs.                    | Months Days   | Hours Min.  | 8. Date of Birth<br>(Month, Day<br>Apr 15,                                      | 1935  | Country)<br>WV                          |  |
|             | and<br>w   |                   | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town or L       | ocation   |   |   |   | 10d. Inside City Limits                 |  |
|             | Maryl<br>a-f sho<br>fied a   | tor               | MD Carroll Sykesville   |  |                            |   |   |   |   | 1 ☐ Yes 2 No                            |  |
|             | h with the<br>23a or 28a<br>st be noti   | Funeral Director  | 10e. Street and Number<br>6703 White Roc  | k Road   | 1.                         | 10f. Zip Code   | 1784  | 1   | 10g. Citizen of What  | •                                       |  |
| 980         | be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by                | 11. Marital Status  1 □ Never Married 2 □ X Married 3 □ Widowed 4 □ Divorced  | 12. Was Decedent Armed Forces? 1                                   | Ever in U.S. 13.           | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 No | lispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | pecity Yes or No-<br>p Rican, etc.)   |   | merican Indian,<br>/hite, etc.<br>White |  |
| 21215-0036  | ~ 3 60   | Completed         | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  2  16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  LPN      |  |                            |   |   | king  | 16b. Kind of Business/Industry Nursing  |   |  |
| Maryland 2  | should be filed withir<br>nd Mental Hygiene.<br>marked other than<br>ımatic event, the M   | To Be Co          | 17. Father's Name ( <i>First, Middle, La</i><br>Carl Connor   | ist)   |                            | T11 1/  | 18. Mother's Nam<br>Anna L                              |   | Maiden Surname)   |   |  |
| lary        | C 6 8 E  |                   | 19a. Informant's Name/Relationship  |  | 1                          | -   |   |   | r, City or Town, Stat   |   |  |
|             | Health<br>tem 27   |                   | Mr. Palmer Ring   | ley (Spous   |                            |   |   |   | 1e, MD 21   |   |  |
| nore        | ages 1 a<br>nt of Hea<br>t: If item<br>/ or othe   |                   | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3  |  | 1                          | ematory or other place  Mem. Pa                           | ce)   | _   | 20c. Location - City Sykesvill  |   |  |
| Baltimore,  | permit. Pages 1 Department of H Important: If ite any injury or ot   |                   | 4 □ Donation 5 □ Other (Spe   |  | Î                          | 2 Name and Addre  | SERFACILITY HOM   | E & CHAF  | PEL. P.A.   | (Box 195)                               |  |
|             | - <del>-                                    </del>   |                   | 23a. Part1. Enter the disease, or complications that caused the path. Do not enter the mode of using, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between |  |                            |   |   |   |   |   |  |
|             | Physician  |                   | Immediate Cause (Final disease or condition resulting in death)   | ily one cause on each  | eterte                     | 70 1  | gener   | CA  | -   | Onset and Death                         |  |
| 1           | /Medical<br>Examiner   |                   | resulting in death)   | Du to (or as   | a consequence of):         | ,   | J   |   |   | 10                                      |  |
| 30,         | ficate be executed physician and sthe burial-transit   | l Examiner        | causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):   |  |                            |   |   |   |   |   |  |
| 68760,      | ficate by physicate by the p   | edica             |   | d  |                            |   | -   |   |   |   |  |
| .O. Box     | The law requires that the death certific the has been signed by the attending page 2 should be detached for use as:  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                            |  |                            |   |   |   | 23d. Date of<br>Month   | delivery<br>Day Year                    |  |
| rds, P.     | w requires that<br>been signed b<br>should be deta   | by                |   |  |                            |   |   |   | Did tobacco use contribute to the cause of death?  ☐ Yes 2☐ No 3☐ Probably 4☐ Unknown |   |  |
| al Records, |  | Completed         |   |  |                            |   |   | 24a. Was a<br>autop:<br>perfor<br>1∐ Yes  | sy prior med? deatl   |   |  |
| Vital       | 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9  | Be                | 25. Was case referred to medical examiner?  | Hospital:  |                            | oth Oth   | _26. Place of Deat                                      |   |   |   |  |
| ō           | ding Phys<br>h.<br>After this<br>funeral di  | n: To             | 1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing   |  |                            |   |   | dome 5 ☐ Assidence 6 ☐ Other (Specify)  28d. Describe how injury occurred       |   |   |  |
| sior        | Attending r death. ector: After by the funer   | atio              |   |  |                            |   |   |   |   |   |  |
| Division    | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the   | Certification:    |   |  |                            |   |   | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |   |   |  |
|             | e Hospital or<br>24 hours afte<br>e Funeral Dir<br>letely filled in  | Medical           | 29a. Certifier 1 Certifying 2 Medical Ex  | Physician: To the best<br>aminer: On the basis of<br>and manner st | f examination and/or i     | th occurred at the tir<br>nvestigation, in my o           | me, date and place<br>opinion, death occu               | , and due to the or<br>rred at the time, o                                      | cause(s) and manne<br>date and place, and   | r as stated.<br>due to the cause(s)     |  |
| <b>.</b>    | To the within 2 To the comple  | Me                | 29b. Signature and title of certifier   | Vinter   | MD                         | 29c. Licens   | e number 3520   | X   | 29d. Date signed (M   | onth, Day, Year)                        |  |
| ,           | 2  |                   | 30. Name and address of person w  | no completed cause of d  | leath (Item 23a) (Type     |   | 1001  | ٠   | 00 1  |   |  |
|             | ) "  |                   | Flavio Krute  | a mo   | 555 Sut                    | h Couter  | Stroot L  | watm  | Noter M   | 021157                                  |  |
|             | Sta<br>Registr   |                   | 31. Date filed (Month, Day, Year)   | 5 2007 Registr   | ar's Signature             | pode  |   |   |   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Amend 10e, perFH, G870, 8/15/07 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** AUSUS 2007 ROBINSO /Medical Deret 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rease Itstown Hasarhel Cente 13 oit mer a torth west Date of Birth (Month, Day, Year) Social Security Number (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Year) 218-84-184 12M 2□ F Director WD Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene.

m 27 Is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Directo Windsur Mill 10e. Street and Number Whisper Woods 10g. Citizen of What Country? 10f. Zip Code 21244 Completed by Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.s. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced Year or Dates: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) econdary (0-12) College (1-4or 5+) Construction aborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be hobinson ပ္ arraine Whalen or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health at Important: If Item 27 Is any Injury or other trau once. 2. Williams moth 200. Place of Disposition (Name of cemeters, crematory or other place)

20c. Location - City or Town, State orraine 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 22. Name and Address of Facility Vauyan C. Greene June 2. June 2. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. beity hoad handallstown Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** phyumania /Medical Due to (or as a consequence of): Examiner AFAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (blacase or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit HIU Diseese Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown cate has been signed , page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No r death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29085 200)

DHMH 17 Rev 1/2001

State

Registrar

Allan

31. Date filed (Month, Day,

5310

32. egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUG 1

5 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |   |                               | 1 - State<br>Registrar  | State of M   | laryland / Dep<br>Co                                     | artment<br>ertificate           |                             |  | F  | Reg. No.                     | 007   | 26182  |  |
|---------------------|---|-------------------------------|---|--|--|---------------------------------|-----------------------------|--|--|------------------------------|---|--|--|
|                     | Physici   | an                            | 1. Decedent's Name (First, Middle, Last)  |  |  |                                 |                             |  | 2. Date of Dea<br>Month                    | nth<br>13                    | 2007  | 3. Time of Death                             |  |
|                     | /Media  |                               | Helen Margaret Sei  |  |  |                                 |                             |  | 8  |                              |   | 4:12 pM                                      |  |
|                     | Examir  | er                            | 4a. Facility Name (If not institution, give si<br>Holy Cross Hospita  | 1  |  | Silv                            | er Sp                       |  |  | Mon                          | unty of Death   |  |  |
|                     | Funeral<br>Director   |                               | 5. Social Security Number 579-32-1483 6. Sex  Usual Residence of Decedent   |  | ge (In yrs. last birthda<br>39 Yrs.                      | Months                          |                             | Under 24 Hrs.<br>ours Min.                     | 8. Date of Birtl<br>(Month, Day<br>4/13/19 |                              | 9. Birthpl<br>Count<br>Nebra                              | ace (State or Foreign<br>ISKA                |  |
|                     | land<br>w   |                               | 10a. State 10b. County  | The second secon |  |                                 |                             |  |  |                              |   |  |  |
|                     | Mary<br>Internation   | tor                           | MD Montgomer  | ·À   | Chevy Ch   | ase                             |                             |  |  |                              |   | 1 ☐ Yes 2X No                                |  |
|                     | th the  | irec                          | 10e. Street and Number  |  |  | 10f. Zip (                      | Code                        |  |  | 10g. Citizer                 | of What Count   | try?   |  |
|                     | 23a unit  | rai                           | 5555 Friendship Blv   | rd.  |  | 2091                            | .0                          |  |  | USA                          |   |  |  |
| 36                  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "naturel", or Items 23e or 28e-f show ship injury or other traumatic event, the Medical Examinar must be notified at ances. | Completed by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 2. Was Deceden Armed Forces 1 Tes 2 If Yes, Give Year or Dates:  | No.  | . Was Decede<br>If Yes, specif  | fy Cuban, M                 | nic Origin? (Spe<br>lexican, Puerto<br>pecify: | ecify Yes or No-<br>Rican, etc.)           |                              | Race - America<br>Black, White, e<br>Dec <i>ify:</i> whit | etc.   |  |
| Ö                   | 2 hou   | ted                           | 15. Decedent's Educ   | ation  | 16a. Dec   | edent's Usual                   | Occupation                  |  |  | 16b. Kind                    | of Business/Ind   | ustry  |  |
| Maryland 21215-0036 | Pin 7.  | pie                           | (Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  [Ife. DO NOT use retired]   |  |  |                                 |                             |  |  |                              |   |  |  |
| 7                   | ed wil  | Соп                           |   | 5 <del>+</del>   | Teac   | her                             |                             |  |  | Educa                        |   |  |  |
| Ind                 | d oth   | Be                            | 17. Father's Name (First, Middle, Last)   |  |  |                                 |                             |  | (First, Middle,                            |                              | mame)   |  |  |
| ₹                   | Men<br>Men<br>Marke<br>Marke<br>Marke   | 2                             | Albin Victor Larson   |  |  |                                 |                             |  | na Herol                                   |                              |   |  |  |
| Mai                 | d 2 sh<br>h and<br>7 is n<br>traun  |                               | 19a. Informant's Name/Relationship (Type<br>Jonathan Seiger   | e, Print)  | 196. Ma  | Strati                          | Street and i                | Numberor <i>Rura</i><br>1. Silve               | a <i>l Route Numbe</i><br>er Sprin         | ng, City or To               | 0wn, State, Zip<br>20910                                  | Code)  |  |
| -                   | 1 and<br>Heath  |                               | 20a. Method of Disposition  |  | 20b. Place of Dis  | position (Name                  | e of                        |  | Date                                       |                              | tion - City or Tox  | wn, State                                    |  |
| <u>o</u>            | ages<br>ant of<br>tt: If it   |                               | 1 ☐ Burial 2 Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)   | moval from State   | Chesapea   | ematory or ott<br>ke Cres       |                             | z 8-15-2                                       | 2007                                       | Belts                        | ville, N  | MD   |  |
| Baltimore,          | artme<br>ortan  |                               | 21. Sign dure of Funeral Service Licen. e   |  | -1258  | 2 Name and                      | Address of                  | Facility                                       |  |                              | MD 20   | 1910   |  |
| m                   | Depa<br>Impo<br>any ir  |                               | 0   |  | R  | app Fu                          | neral                       | & Crem   | .Sv.933                                    | Gist                         | Av.Sil  | ver Spring                                   |  |
|                     | Physician /Medical Examiner   | Examiner                      | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to amnufact cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Pneumon Due to (or a:  Acute M Dus to (or a:  Dehydra  | ia s a consequence of):  [yocardial s a consequence of): |                                 |                             |  |  |                              |   | Approximate Interval Between Onset and Death |  |
| .O. Box 68760,      | The law requires that the death certificate be executed site has been signed by the attending physicien and page 2 should be detached for use as the burial-transit   | by Physician/Medical E        | JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown   | c. If yes, outcom<br>1 □ Live birth<br>4 □ Pregnant a<br>9 □ Unknown   |  | 230                             | I. Date of deliver<br>Month | ry<br>Day Year                                 |  |                              |   |  |  |
| ds, P               | uires tha<br>signed<br>Id be dei  | d by P                        | Part II. Other significant conditions cont<br>Metabolic Acidosis  |  | but not resulting in the                                 | underlying ca                   | use given in                | Part I.  | 23e. Did to                                | 1.                           |   | e cause of death?<br>ably 4 []Unknown        |  |
| Vital Records,      | : The law requir<br>cate has been si<br>page 2 should I   | Completed                     | Renal Failure   |  |  |                                 |                             |  | 24a. Was a autop perfor                    | sv                           |   | osy findings available apletion of cause of  |  |
| ita                 | icion: Th<br>certificate<br>rector, pag   | BeC                           | 25. Was case referred to medical  |  |  |                                 | 26.                         | Place of Death                                 | Check only or                              | -                            | 103   | 20110  |  |
| <b>&gt;</b>         | hysic<br>his ce<br>I direc  | To                            | examiner?<br>1 ☐ Yes 2 No Ho  | spital: 1 npat   | ient 2 ER/Outpati  | ent 3 DOA                       | Other: 4                    | Nursing Ho                                     | me 5 🗆 Resid                               | lence 6                      | Other (Specify  | )  |  |
| 0                   | ng Pl   |                               | 27. Manner of Death  1 Solution 1 5 ☐ Pending   | 28a. Date of Inj<br>(Month, D  | ury 28b. Time  |                                 | c. Injury at<br>Work?       |  | 28d. Describe h                            | ow injury o                  | ccurred   |  |  |
| sio                 | tendi<br>leath.<br>tor; A<br>the fu   | cati                          | 2 Accident investigation 3 Suicide 6 Could not be   |  |  | М                               |                             | 2 🗆 No   |  |                              |   |  |  |
| Division of         | or At<br>after of<br>Direct<br>in by  | Certification:                | 4 Homicide determined   | 28e. Place of Ir<br>building, e  | njury - At home, farm, :<br>ntc. <i>(Specify)</i>        | treet, factory,                 | office                      |  | 28f. Location (S<br>City or Tow            | itreet and N<br>m, State)    | lumber or Rural   | Route Number,                                |  |
| _                   | To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,  | edicai C                      | 29a. Certifier (Check only one)  (Check only one)   | cian: To the bes<br>er: On the basis<br>and manner s   | t of my knowledge, de<br>of examination and/or<br>tated. | ath occurred a investigation, i | t the time, d               | ate and place,<br>n, death occurr              | and due to the ded at the time, d          | cause(s) and<br>date and pla | d manner as sta<br>ace, and due to                        | ated.<br>the cause(s)                        |  |
|                     | To th<br>within<br>To th  | Me                            | 29b. Signature and title of certifier   | -  |  |                                 | License nui                 | mber   |  | 29d. Date s                  | igned (Month, L   | Day, Year)                                   |  |
| )                   |   |                               | > Kshama  | han  | P  | De                              | 50825                       |  | 8  | 3-14-2                       | 2007  |  |  |
|                     | 6   |                               | 30 Name and address of nerson who are   | anlatad sauce of   | death (Item 23a) (Typ                                    | e, Print)                       | inc 1/1                     | 20010  |  |                              |   |  |  |
| _                   | 9   |                               | Kshama Garg Holy C  |  |  | er Spr                          | ıng,MI                      | 770310   |  |                              |   |  |  |
|                     | Sta<br>Registr  |                               | 31. Date filed (Month, Day, Year) AUG 1 5 200   | 32 Regist  | trar's Signature   | - 10                            |                             |  |  |                              |   |  |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** AUGUST 13 2007 MARY FRANCES SINSKY /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner ARUNDE Amne BALTIMOR BACHINGTON MEDICAL PRITE BURNIE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days Months Hours 1 □ M 2**X**) F Director 59 MAY 10, MARYLAND 217-46-4985 1948 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 7863 CRILLEY RD. 21060 Funeral APT. 476 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 XX If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: þ 3 ₩idowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME MAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH GENE HOLY BLANCHE VIVIAN SMITT ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CINDA KOCH / DAUGHTER SKYLINE AVE.; ODENTON, MD 21113 431 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition AUGUST 14, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 ☐ Other (Specify) 2007 METRO CREMATORY CATONSVILLE, MARYLAND 22. Name and Address of Facility Funeral Service KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY. SE. GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACCUSENT Physician /Medical Due to (or as a consequence of) Examiner 101 M San trially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown ate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature title of certific Vu i 45149 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ren Burnie 301 Hospital Drive 32. gistrar's Signature 31. Date filed (Month Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month DENNIS Μ. SESAK 1230 PM 200-/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** THE JOHNS HOSPITAL BACTMURE C Under 1 Year I I Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 9. Birthplace (State or Foreign Country) PA 5. Social Security Number 7. Age (In yrs. last birthday) Funeral sex 1∐XM 2∐F Days Hours 54 175-44-3826 May 18, Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Howard Glenwood 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21738 14569 Dorsey Mill Road USA Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medionce. Elementary/Secondary (0-12) College (1-4or 5+) Engineering Electrical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Sesak Margaret Brillo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ms. Mary M. Sesak (Sister) 229 Vinal St., Rockport, Maine 04841 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State All County Cremation 8/14/2007 Sykesville, MD 21. Signature of Funeral Service Licensee P.A. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL, P.A.
Sykesville, MD 21784 (410)-795-1400 M00764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MULTIPUE YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Vital Records, P.O. Box 68760, physician Physician/Medical as the I attending for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate 2 X (No 1□ Yes Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3□ DOA Division or 27: Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EAVITA SHARMA. HOPKINZ GOD N. WOLFE ST RAUMORE JOHNS MUDITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 1 5 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month\_ **Physician** Settle August 00 29 William 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Medical Center Johns Hopkins Baltimare If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 15, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1⊠M 2□F Yrs. 1951 Director Pennsylvania 212-56-3285 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. snt: If item 27 is marked other then "naturel", or items 23s or 28s-f show ury or other traumatic event, If a Medical Exactinating the fooling at 10a. State 10b. County 10c. City. Town or Location 1X Yes 2 □ No Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U. S. A. 21205 5020 E. Hoffman St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contracting 10 Carpenter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Malinda Fisher William Raymond Settle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5018 Erdman Avenue, Baltimore, Maryland 21205 Debra Eline (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 08/ 14/2007 Baltimore, Maryland Bayview Crematory 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road, Baltimore, Maryland 21236 in a U 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) gastrointestinal Dleeding Physician days /Medical ue to (or as a consequence of): Examiner repatic CITHUSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed alcohol dependence Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ete hes been signed by the a page 2 should be detached in 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ this : After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Division 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29c. Licensa number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier Res - 000 Kulonott 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Christopher Klebnoff 4940 Faskun 4940 Fastern Avenue Battimore, MD 21224

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) AUG 1 5 2007

15

ODIGINIAL

32. Registrar's Signature

ORIGINAL

32. Registrar's Signature

Chardon

31. Date filed (Month Day, Year)

State Registrar

|                     |  | -              | For State   | State of                                   | Marylan                            |                  | artment of<br>rtificate of                   |                             |                           |                                   | 7                        | 007                           | 26187                           |  |
|---------------------|--|----------------|---|--|------------------------------------|------------------|--|-----------------------------|---------------------------|-----------------------------------|--------------------------|-------------------------------|---------------------------------|--|
|                     |  |                | Registrar  1. Decedent's Name (First, Middle  | (not)                                      |                                    | 061              | incate of                                    | Dealii                      | - 1                       | 2. Date of Dea                    | Reg. No.                 |                               | 3. Time of Death                |  |
| Е                   | Physicia   | _              | William C.  |  | ı .Tr                              |                  |  |                             |                           | Month                             | Day                      | Year<br>2007                  |                                 |  |
| 4                   | /Medic   | 200            |   |  |                                    |                  | 4b. City, Town,                              | or Location                 | of Death                  | AUGUS.                            | -                        | unty of Death                 |                                 |  |
| )                   | Examin   | er             | 4a. Facility Name (If not institution Saint Josep   |  |                                    | ton              | 4b. City, rowii,                             |                             | OWSC                      | n                                 | 40.000                   |                               | imore                           |  |
|                     | <del> </del>   | Щ              | 5. Social Security Number   |  | 7. Age (In yrs.                    |                  | If Under 1 Yea                               |                             |                           | 8 Date of Birt                    | h                        | 9 Rirth                       | place (State or Foreign         |  |
| 1 m                 | Funeral Director   |                | 212-42-4271   | 1 <b>№</b> M 2□F                           | 61                                 | Yrs.             | Months Day                                   |                             | Min.                      | Sept.                             | Y Year) 19               | - L Coui                      | ryland                          |  |
|                     |  | -              | Usual Residence of Decedent   |  |                                    |                  |  |                             |                           |                                   | •                        | 110                           |                                 |  |
|                     | /land<br>ow<br>at  |                | 10a. State 10b. County  | •  | 10c. Cit                           | y, Town or Lo    |  |                             |                           |                                   |                          |                               | 10d. Inside City Limits         |  |
|                     | Man<br>-f sh<br>fied   | to             | MD Balt   | imore                                      |                                    | Esse             | Х  |                             |                           |                                   |                          |                               | 1 □ Yes 2 🔼 No                  |  |
|                     | r 286  | Director       | 10e. Street and Number  |  |                                    |                  | 10f. Zip Code                                |                             |                           |                                   | 10g. Citizen             | of What Cou                   | intry?                          |  |
|                     | th wit   |                | 110 Riversi   | de Drive                                   | 9                                  |                  | 21.  | 221                         |                           |                                   |                          | USA                           |                                 |  |
|                     | ems deal   | Funeral        | 11. Marital Status  | 12. Was Dece<br>Armed Fo                   | dent Ever in U                     | .S. 13.          | Was Decedent of                              | Hispanic Or<br>Iban, Mexica | rigin? (Spe<br>an, Puerto | cify Yes or No-<br>Rican, etc.)   |                          | Race - Ameri<br>Black, White  |                                 |  |
| 9                   | after<br>or it   | 3              | 1 Never Married 2 Marr  | If Yes, Giv                                | e                                  |                  | 1 □ Yes 2 □XN                                | o Specify                   | r:                        |                                   | Sp                       | ecify: W                      | hite                            |  |
| g                   | nours<br>ural",<br>LExa  | d by           | 3 Widowed 4 Divorced  | Year or Da                                 | ates:                              | 10 0             | dent's Usual Occ                             |                             |                           |                                   | 16h Kind o               | of Business/Ir                |                                 |  |
| Ϋ́                  | "nati  | lete           | 15. Decedent<br>(Specify only highes  | 's Education<br>st grade completed)        |                                    | I (Give          | kind of work don<br>DO NOT use reti          | e durina mo                 | st of worki               | ng                                | Tob. Kind C              | Ji Busilless/II               | laustry                         |  |
| 2                   | withir   | Completed      | Elementary/Secondary (0-12)<br>10th   | College (1                                 | -4or 5+)                           |                  | penter                                       | /                           |                           |                                   | U                        | nion                          | 101                             |  |
| Maryland 21215-0036 | filed<br>Hygi<br>ther<br>int, tl   |                | 17. Father's Name (First, Middle,   | Last)                                      |                                    |                  |  | 18. Moth                    | er's Name                 | (First, Middle,                   | Maiden Sur               | rname)                        |                                 |  |
| aŭ                  | d be<br>ental<br>ced o   | To Be          | William C. S  | Sampson :                                  | Sr.                                |                  |  | Ma                          | rie                       | Hanz                              | lik                      |                               |                                 |  |
| <u>-</u>            | should be filed within 72 hours after death with the Maryland ind Mental bygiene. In marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at   | F              | 19a, Informant's Name/Relations   |  |                                    | 19b. Maili       | ng Address (Stre                             | et and Numb                 | ber or Rura               | al Route Numb                     | er, City or To           | own, State, Zi                | ip Code)                        |  |
| Ma                  | nd 2 state at trace  |                | Rita A.Samps  | on /wife                                   | е                                  | 110              | River  | side                        | Driv                      | e Bal                             | timor                    | e MD                          | 21221                           |  |
| ē,                  | s 1 al<br>f Hea<br>item<br>othe  |                | 20a. Method of Disposition  |  | 20b. F                             |                  | osition (Name of<br>matory or other p        |                             | . [                       | ate                               | 20c. Locati              | ion - City or T               |                                 |  |
| 9                   | Page<br>ent o<br>nt: If<br>ry or   |                | 1 ☐ Burial 2 ☑ Cremation<br>4 ☐ Donation 5 ☐ Other (S   |  | State Ba                           | yview            | Crema  | tory                        | 8/1                       | 3/07                              | Balt                     | imore                         | e MD                            |  |
| altimore,           | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. | Ιŧ             | 21. Signulure   |  | //                                 | 2                | 2. Name and Add                              | ress of Faci                | lity 30                   | 0 Mac                             | e Ave                    | .Balt                         | o. MD                           |  |
| m                   | Dep<br>Per<br>any  |                | 1/1/1/KH  | a FYOUD                                    | 1                                  | c                | onnell                                       | y Fun                       |                           |                                   |                          |                               | 21221                           |  |
| 11                  | 75   |                | 23a. Part1. Enter the disease, or shock, or heart failure. List   | complications that controls one cause on e | aused the deat                     | h. Do not en     | ter the mode of o                            | ying, such a                | s cardiac                 | or respiratory a                  | rrest,                   |                               | Approximate<br>Interval Between |  |
|                     | Physician  |                | Immediate Cause (Final disease or condition   | 653500                                     |                                    |                  |  |                             |                           |                                   |                          |                               | Onset and Death                 |  |
| )                   | /Medical   |                | resulting in death)  Due to (or as a consequence of):   |  |                                    |                  |  |                             |                           |                                   |                          |                               |                                 |  |
|                     | Examiner   |                | Constitution and distance   | , URI                                      | NARY 1                             | RACT             | INFECT                                       | ION                         |                           |                                   |                          |                               |                                 |  |
| .7                  |  | ne             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Dus to                                     | or as a cur sec                    | juanca of):      |  |                             |                           |                                   |                          |                               |                                 |  |
| V                   | ransi  | Examiner       | Cause (Disease or injury that initiated events  | · ACU                                      | TE REN                             | IAL_E            | ALLURE                                       |                             |                           |                                   |                          |                               |                                 |  |
| ő                   | e exe  | <u> </u>       | resulting in death) Last  | 100  | or as a consec                     |                  | ··· 2···. 3   2···. 1   2···. 1   2···. 1··· | ./\me_1.1\/                 |                           |                                   |                          |                               |                                 |  |
| 8760,               | requires that the death certificate be executed<br>een signed by the attending physician and<br>nould be detached for use as the burial-transit  | dical          |   | d. ME.I                                    | HROF 11                            | ENLE             | EPHALOF                                      | 'HITT                       |                           |                                   |                          |                               |                                 |  |
| မှ                  | ertific<br>ding p  | Physician/Me   | IF FEMALE:  | 23c If yes out                             | come pf pregn                      | ancv             |  |                             |                           |                                   | 004                      | L Date of doli                | von.                            |  |
| Вох                 | ath c  | ian/           | 23b. Was decedent pregnant in the past 12 months?   | 1 ☐Live b                                  | ointh 2 ☐ Feta<br>ant at time of o | al death 3       | □Ectopic pregna<br>□ Other (specify)         |                             |                           |                                   | 230                      | I. Date of deli<br>Month      | Day Year                        |  |
| O.                  | the a  | ysic           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9□Unkn                                     |                                    | Jean 5           | Other (specify)                              |                             |                           |                                   |                          |                               |                                 |  |
| <u>α</u>            | w requires that the death certific<br>been signed by the attending p<br>should be detached for use as  | P              | Part II. Other significant conditi  | ons contributing to d                      | eath but not res                   | sulting in the u | underlying cause                             | given in Part               | II.                       | 23e. Did 1                        | tobacco use              | contribute to                 | the cause of death?             |  |
| ds,                 | sign<br>d be   | d by           |   |  |                                    |                  |  |                             |                           | 1 🗆                               | Yes 2 X                  | No 3□Pro                      | obably 4 □Unknown               |  |
| Ö                   | ~ 0 70   | Completed      |   |  |                                    |                  |  |                             |                           | 24a, Was                          | an 2                     | 24b. Were au                  | topsy findings available        |  |
| æ                   | has<br>has   | m              |   |  |                                    |                  |  |                             |                           |                                   | psy<br>ormed?            | prior to death?               | completion of cause of          |  |
| B                   |  |                | 25. Was case referred to medica   | 1  |                                    |                  |  | 26 Plac                     | re of Deat                | 1 Yes<br>h Check onl              | 2 No                     | 1∐Yes                         | 2□ No                           |  |
| or Vital Records,   | Physician:<br>this certific<br>ral director,   | o Be           | examiner?   | Hoepital:                                  | Inpatient 2                        | ] ER/Outpatie    | nt 3 DOA                                     | Other:                      |                           | me 5□Resi                         |                          | Other (Spec                   | cify)                           |  |
| 0                   | iding Phys<br>h.<br>: After this<br>funeral dir  | 2 :            | 27. Manner of Death   | 28a. Date                                  | of Injury                          | 28b. Time        |  | njury at<br>Vork?           |                           | 28d. Describe                     |                          |                               |                                 |  |
| Division            | Attending r death. ector: After by the fune  | atio           | 1 Natural 5 Pendir<br>2 Accident investi  | y ·  | th, Day Year)                      | Injury           |  | Yes 2                       | □No                       |                                   |                          |                               |                                 |  |
| Vis                 | or Attenceath<br>after death<br>Director:<br>in by the   | ific           | 3 Suicide 6 Could<br>4 Homicide detern  | inca   Zoe, Flace                          | of injury - At h                   | nome, farm, s    | treet, factory, office                       | ce                          |                           | 28f. Location (                   | (Street and Nown, State) | Number or Ru                  | ıral Route Number,              |  |
| Ö                   | tal or<br>s afte<br>ai Dir<br>ed in  | Certification: |   |  |                                    |                  |  |                             |                           |                                   |                          |                               |                                 |  |
|                     | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the   |                | 29a. Certifier Certifying (Check only 2 Medical   | ng Physician: To the<br>Examiner: On the b | e best of my kn                    | owledge, dea     | th occurred at the                           | e time, date a              | and place,<br>eath occur  | and due to the<br>red at the time | e cause(s) ar            | nd manner as<br>lace, and due | stated.<br>to the cause(s)      |  |
|                     | To the Hos<br>within 24 h<br>To the Fun<br>completely  | Medical        | one)  | and man                                    | ner stated.                        |                  |  |                             |                           |                                   |                          |                               |                                 |  |
|                     | To the<br>within<br>To the   | 2              | 29b. Signature and title of certified   | 1 (1)                                      | ehter                              | m.E              | 29c. Lice                                    | ense number                 |                           |                                   | 29d. Date s              | signed (Month                 | ~                               |  |
|                     |  |                | 1000  |  |                                    |                  |  | ) 414                       | 10                        |                                   | itado                    | 125-11                        | 12001                           |  |
|                     | A  |                | 30. Name and address of person  | who completed caus                         | se of death (Ite                   |                  |  |                             |                           |                                   |                          |                               | _ , ,                           |  |
|                     | <i>y</i>   |                | 31. Date filed (Month, Day, Year,   | MEHTO                                      | M D<br>Registrar's Sign            | 7671             | OSLER  | DRIV                        | E, T                      | OWSON.                            | MAR                      | YLAND                         | 21204                           |  |
| 14                  | St<br>Regist   | ate<br>rar     | NIC 1 5 70  |  | iogistiai 3 digi                   | Brank            | 0  |                             |                           |                                   |                          |                               |                                 |  |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  | 1 - For<br>State<br>Registrar   | State of Mar  |                                       | artment of Heartificate of De  | eath  | Reg.   | 6001  | 26188  |
|--|---|---|---------------------------------------|--|---|--|---|--|
| Physician<br>/Medical  | 11 - 211  |   | EWAR                                  | ~  |   | 2. Date of Death                                   | Pay Year  | 3. Time of Death                                   |
| Examiner   | 4a. Facility Name (If not institution, g ANNE ARUNDEL MED   | ICAL CENTER   |                                       | 4b. City, Town, or Lo ANNAPOLIS  If Under 1 Year   If                                |   |  | 4c. County of Death                               | DEL  |
| Funeral<br>Director  | 212-20-2529   | . Sex<br>1□ M 2 F 81  | (In yrs. last birthday)<br>Yrs.       |  | Hours Min.  | B. Date of Birth<br>(Month, Day, Ye.<br>2/21/192   | ar) 9. Birth<br>Cou<br>5 MARY                     | place (State or Foreign<br>intry)<br>LAND          |
| Maryland a-f show  | Usual Residence of Decedent  10a. State  10b. County  MD  ANNE AR   |   | Oc. City, Town or Lo                  |  |   |  |   | 10d. Inside City Limits 1 ☐ Yes 2 🛣No              |
| with the   | 10e. Street and Number 404 MELROSE AVE  | MITE  |                                       | 10f. Zip Code 21061  |   |  | Citizen of What Cou                               | intry?   |
| ite; Marylating Z IZ IS-0050  s 1 and 2 should be filed within 72 hours effer death with the Maryland f Health and Mental Hygiene litem 27 is marked other then "naturel", or items 23a or 28a-f show other traumatic event, ite Medical Exercise more provided at To Re Completed by Funeral Director   | 3 ∰Widowed 4 □ Divorced   | 12. Was Decedent Ev<br>Armed Forces?  |                                       | Was Decedent of Hispa<br>If Yes, specify Cuban, I                                    | anic Origin? (Spec<br>Mexican, Puerto R<br>Specify: |  | S . A .  14. Race - Amer Black, White Specify: WH |  |
| other then "nature out, the Medical E  | 15. Decedent's (Specify only highest 15) Elementary/Secondary (0-12)  | Education<br>grade completed)<br>College (1-4or 5+)                               | (Give                                 | dent's Usual Occupation<br>kind of work done duri<br>DO NOT use retired)  ER MANAGER | on<br>ing most of working                           | g  | . Kind of Business/li                             | ndustry  |
| d be filed intal Hyginal Hygin | 17. Father's Name (First, Middle, La  | st)   | , 202                                 | 18   |   | (First, Middle, Maid                               | len Sumame)                                       |  |
| should ind Men ind Men umarke  | FRANK COLUMBIA  19a. Informant's Name/Relationship  | (Type, Print)   | 19b. Maili                            | ng Address (Street and   | JOSEPHINE Number or Rural                           |  | NOWN<br>ty or Town, State, Zi                     | p Code)  |
| 0 0  | MR • FRANK STEWAR!  20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe                               | ☐Removal from State   | 20b. Place of Dispo<br>cemetery, crei | ENMONT AVE. sition (Name of matory or other place) EN MEM. PK.                       | Da  | 20c  | D 21061<br>Location - City or T<br>EN BURNIE      |  |
| Dermit. Pag<br>Department<br>Important: I<br>any injury o  | 21. Signature of Burney Service Lie   | • •   |                                       | 2. Name and Address of   | of Facility SIN                                     | GLETON F   | UNERAL HOI<br>IE, MD 210                          | 4E   |
| Physician<br>/Medical<br>Examiner  | 3a. Jan1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) | aa.   | ne death. Do not end                  | er the mode of dying, s  | such as cardiac or                                  | respiratory arrest,                                | 4 * .   | Approximate<br>Interval Between<br>Onset and Death |
| ate be executed system and he burial-transit   | A   | c   | consequence of):                      | g Widl   | Ly IV   | Wasta  | pr(   | PHONING.   |
| death certif   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of<br>1 □ Live birth 2<br>4 □ Pregnant at tir<br>9 □ Unknown | Fetal death 3                         | Ectopic pregnancy Other (specify)  |   |  | 23d. Date of delin                                | very<br>Day Year                                   |
| The law requires that the law requires that the page 2 should be detached by the page 2 should be detached by Physe  | Partit. Other significant condition   | s contributing to death but   | not resulting in the u                | nderlying cause given  | in Part I.  | 23e. Did tobacc                                    | co use contribute to                              |  |
| The lay to has age 2   |   |   |                                       |  |   | 24a. Was an<br>autopsy<br>performen<br>1 ☐ Yes 2 🗓 | ? prior to c<br>death?                            | opsy findings available ompletion of cause of      |
| Physician: This certifica  | examiner?   | Hospital:   | 2 ☐ ER/Outpatie                       | Other  | 6. Place of Death                                   |  | e 6 □Other (Spec                                  | ıfy)   |
| LIVISION OF VICAL tel or Attending Physician: se effer death. al Director: Affer this certifica ed in by the funeral director.   |   | 28a. Date of Injury<br>(Month, Day )  | Year) 28b. Time o                     | of 28c. Injury at Work?  M 1 □ Yes   | t 2<br>s 2 □No                                      | 8d. Describe how i                                 | njury occurred                                    |  |
| DIVI:  | 4 Homicide determin   | ed 28e. Place of Injury<br>building, etc.   | y - At home, farm, st<br>(Specify)    | reet, factory, office  | 2   | 8f. Location (Stree<br>City or Town, S             | t and Number or Ru<br>tate)                       | ral Route Number,                                  |
| he Hospi<br>in 24 hou<br>he Funer<br>pletely fill  | 29a. Certifier 1 Contitying (Check only 2 Medical Exone)  | Physician: To the bast of caminer: On the basis of e and manner state             | xamination and/or in                  | vestigation, in my opin  | ion, death occurre                                  | d at the time, date                                | and place, and due                                | to the cause(s)                                    |
| To t<br>To t   | 29b. Signature and title of certifier.  | J Dele  | on str                                | 29c. License n   | 214:  | 38 29d.  | Pare signed (Month                                | 1. Day, Year)<br>14, WU7                           |
| $O_j$  | 30. Name and address of person w  | 10 dimpleted cause of dea   | ath (Item 23a) (Type.                 | Print)<br>ENSE   | HGHWI   | AT ANO   | IAPOLIS W   | 1021401  |
| State<br>Registrar   | BULK A  |   | 's Signature                          | edi.   |   |  |   |  |

| 07-06212     |  |
|--------------|--|
| Richard Saho |  |

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| Richard Sabo  | State of Maryland / Departmer 1- For State Certificat   | o of Dooth  | eg. No. 2007 2518   |
|---|---|---|---|
| Physician/  | Registrar  1. Decedent's Name (First, Middle,Last)  | 2. Date of Dea  | ath 3. Time of Death  |
| Medical Examiner  |   | August 12   | 2, 2007 1130 hrs  |
|   | 4a. Facility Name (if not institution, give street and number) Atlantic General Hospital                              | 4b. City, Town, or Location of Death  Berlin  | Worcester   |
| Funeral   | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd  | rth(MM/DD/YYYY) 9. Birthplace (State or Foreign   |   |
| Director  | 149-34-8380   1XM 2 F   62  | Yrs.   Months   Days   Hours   Min.   Sept.   | 27,1944 Country) PA   |
| any   | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or  | Location  | 10d. Inside City Limits   |
| *   | NJ Burlington Marlton   | l interest  | 1 XYes 2 No   |
| the Maryland a or 28a-f sh tiffed at once   | 10e. Street and Number  | 10f. Zip Code   | 10g. Citizen of What Country?   |
| h the Na or lottified   | 17 Charter Oak Lane   | USA   |   |
| r death with the Maryland or items 23a or 28a-f show must be notified at once. Funeral Director   | 1 Nover Married 2 X Married Armed Forces?   | <ol> <li>Was Decedent of Hispanic Origin? (Specify Yes or Note of Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> </ol> | o- 14. Race - American Indian, Black, White, etc.                             |
| Rer der Pr., orri   | 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year   | 1 Yes 2 X No specify:   | Specify: White  |
| ours aft atural' xaming   | or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. De                                   | cedent's Usual Occupation (Give kind of work done ring most of working life, DO NOT use retired)                              | 16b. Kind of Business/Industry  |
| 36<br>in 72 h<br>han "r<br>lical E  | Elementary/Secondary (0-12) College (1-4 or 5+)  5+ PI  | resident  | Tool & Machine<br>Company   |
| 5-0036 ed within 72 hour lygiene. other than "natu the Medical Exau Completed   | 17. Father's Name (First, Middle, Last)   | 18.Mother's Name (First, Middle,  |   |
| 21215-0036 Auld be filed within 7 Mental Hygiene. marked other than e event, the Medica fo Be Comple  | Gilbert Sabo  |   | ning  |
|   |   | Mailing Address (Street and Number or Rural Route Nu<br>7 Charter Oak Lane, Burlin  |   |
| Baltimore, MD permit Pages I and 2 shopermine to 4 Health and Important: If item 27 is injury or other traumat  | 20a. Method of Disposition 20b. Place of  | Disposition (Name of cemetery, Date   | 20c. Location - City or Town, State   |
| nore<br>ages 1<br>art of 1<br>ar: If i  | Dunial 2 A Cremation 3 Removation state   | y or other place) gh Crematory 08/15/200  | 7 Camden, New Jersey  |
| altir<br>mit F<br>partme<br>portau<br>ury or  | 21. A nature of Funeral Service License   | 22. Name and Address of Facility Ruck Tow   | son Funeral Home, Inc.  |
| 91  | 23a. Part I Enter the disease, or complications that caused the death. Do not   | 1050 York Rd., Towson,  |   |
| Physician<br>/Medical   | failure. List only one cause on each line.  |   | Between Onset and Death   |
| Examiner  | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):                     | Wasculai disease  |   |
|   | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):                           |   |   |
| nine  | if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated                       |   |   |
| ted Insit   | events resulting in death) Last  Due to (or as a consequence of):   |   |   |
| 50, te be executed ysician and burial - transit   | X UNPENDED AMENDED AMENDED #23a,27, perME, G8670,   | 8/22/O7 TT  |   |
| 760, cate be physical he buri   | #23a,27,penile,60070,  IF FEMALE:  23c. If yes, outcome of pregnancy  |   | 23d. Date of delivery   |
| Box 68760, he death certificate by the attending physic hed for use as the burthesician/Mec   | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death 5                       | Fetal death 3 Ectopic pregnancy  Other (Specify)  | Month Day Year  |
| by the atterched for u  | 1 Yes 2 No 9 Unknown g Unknown  |   |   |
| P.O. B es that the d igned by the detached by Phy   |   | in the enderlying edges given in the in   | tobacco use contribute to the cause of death?  es 2 No 3 ✓ Probably 4 Unknown |
| of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by uneral director, page 2 should be detach   |   | 24a. Wa   |   |
| Division of Vital Records, tal or Attending Physician: The law require is after division. The law require in Director: After this certificate has been sived in by the funeral director, page 2 should be artification: To Be Completed |   | peri  | ppsy prior to completion of cause of death?  2 ✔ No 1 Yes 2 No                |
| Vital Rec<br>ysician: The his certificate<br>director, page   | OF Was associated to madical  | 26.Place of Death (Check only one)  | 2 No 1 Yes 2 No   |
| Vital tysician this cert directo  | 1 Yes 2 No inpatient 2 V ER/Out   | patient 3 DOA Other Nursing Home 5  | Residence 6 Other:  |
| n of ding Ph  |   |   | e how injury occurred   |
| ivision<br>or Attend<br>after death.<br>Director:<br>I in by the J  | 1 X Natural 5 Pending 2 Accident Investigation  | The street factory office building etc. 28f Location  | (Street and Number or Rural Route Number, City                                |
| Division o<br>spital or Attending<br>hours after death.<br>neral Director: Afte<br>filled in by the fune<br>Certification:  | 3 Suicide 6 Could not be determined (Specify)   | m, street, factory, office building, etc. 28f. Location or Town,  |   |
|   |   | h occurred at the time, date and place, and due to the ca   | use(s) and manner as stated.  |
| To the Hos within 24 h To the Fur completely  | one) 2 Medical Examiner:On the basis of examination and/or in and manner states.                                      |   |   |
| Š   | 29b. Signature and fille off certifier  | 29c. License number O.C.M.E.  | 29d. Date signed (Month, Day, Year) August 13, 2007                           |
|   | 20 Name and address of parent who completed source of death /hom 22a)   | O.O.IVI.L.  | gaot 10, 2001   |
|   | 30. Name and address of person who completed cause of death (Item 23a)  Susan Hogan MD. Assistant Medical Examiner 11 | 1 Penn Street, Baltimore, MD 21201  |   |
| Stat  |   | South   |   |
| Registra  | D LIGHT OF LOOK   North State   |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #18, perFD, 6870, 8/21/07 TT Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 12:52 PM Takao Lewis Sato August, 12 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville <u>Shady Grove Adventist Hospital</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1**X** M 2□ F Yrs. 58 August 10, 1949 Japan Director 263-13-1653 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Eximiliner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director Rockville Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a / 20853 United States 4900 Norbeck Road Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🛣 No Specify: ģ 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medicine Physician 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kazve Yamasaki ပို Yoshimasa Sato 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: if item 27 is any injury or other trau once. 4900 Norbeck Road Rockville, Maryland 20853 Beverly K. Sato/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. Date 20c. Location - City or Town, State 20a. Method of Disposition ntgomery
torium Inc. 14, 2007

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Licensee M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death L8 months Immediate Cause (Final Non Hodgkins Lymphoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 1 week Sepsis Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ospital or Attending Physician: The law requires that the death certificate be executed hours after death.

hours after death.

uneral Director: After this certificate has been signed by the attending physician and siy filled in by the Internal director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one)

within 24 hours a To the Funeral C

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

25 State Registrar

Medi

29b. Signature and title of certified

31. Date filed (Month, Day, Year)

AUG I

9707 Medical Center Drive, #300, Rockville, Maryland 20850 Manish Agrawal, M.D. 32. Resistrar's Signature 2007

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D62234

29d. Date signed (Month, Day, Year)

August 13, 2007

07-05982 Barry Shorts

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| 100  | <br>13 15 | 0.1 |
|------|-----------|-----|
| 20   | 26        | 1   |
| 6- 0 | 60 1      |     |

|  |                                 |                | or State  |                 | -                     |                      | Certifi         | icate of i                              | Death                      |                        |                           |                       |                                 | Reg. No           |                    |                     | To a f Dagth  |
|--|---------------------------------|----------------|---|-----------------|-----------------------|----------------------|-----------------|---|----------------------------|------------------------|---------------------------|-----------------------|---------------------------------|-------------------|--------------------|---------------------|---|
| Physici<br>al Exami  | an/<br>iner                     | 1. !           | iistrar<br>Decedent's Name (First, Middle                         |                 | rry S                 | hort                 | s               |   |                            |                        |                           |                       | Date of De<br>Month<br>August 4 | Day<br>1, 200     |                    |                     | 3. Time of Death<br>1915 hrs                        |
|  |                                 | 4a.            | Facility Name (if not institution                                 |                 |                       | ımber)               |                 | 41                                      | . City, Tov<br>Baltimo     |                        | ocation of                | Death                 |                                 | 14                | c. County of       | / A                 |   |
|  |                                 |                | 11 W. 20th Street Apt   |                 |                       | 7 1                  | (In yrs. last I | hirthday)                               | If Under                   |                        | If Under                  | 24Hrs.                | 8. Date of                      | Birth (MN         |                    |                     | place (State or                                     |
| Funeral<br>Director  |                                 | 5.             | Social Scoting Hamber   | 6. Sex          | M 2 F                 | 1                    | 32              | Yrs. Months Days Hours Min.             |                            |                        |                           |                       | 06/02                           |                   |                    | I Foreign           | ntry)Mary1and                                       |
|  | 1                               | _              | ual Residence of Decedent   |                 |                       |                      | Oc City To      | wn or Location                          | n                          |                        |                           |                       |                                 |                   |                    |                     | 10d. Inside City Limits                             |
| w an   |                                 |                | a. State 10b. County  |                 |                       | 1                    |                 | Ltimore                                 |                            |                        |                           |                       |                                 |                   |                    | - 1                 | 1 X Yes 2 No  |
| /land<br>-f sho  | į                               | IVI:           | aryland N/A e. Street and Number                                  |                 |                       |                      |                 | T T T T T T T T T T T T T T T T T T T   | 10f. Zip C                 | ode                    |                           |                       |                                 | 10g. C            | itizen of Wh       | at Counf            | try?  |
| death with the Maryland<br>or items 23a or 28a-f show any<br>must be notified at once.   | Director                        | 10             | 3542 - 4th S  | tre             | et                    |                      |                 |   | 2                          | 1225                   |                           |                       |                                 |                   | U.S                | .A.                 |   |
| vith th  |                                 |                | . Marital Status  |                 | 12. Was De            |                      | ver in U.S.     | 13. Was                                 | Decedent                   | of Hisp                | anic Origi                | n? (Spe               | ecify Yes or<br>Rican, etc.)    | No-               |                    | - Americ<br>e, etc. | an Indian, Black,                                   |
| eath v<br>item   | Funeral                         | 1              | X Never Married 2 M   | i               | Armed F               | 2                    | X No            |   |                            |                        |                           | rueitoi               | Alcan, Clo.,                    |                   |                    |                     | -1-   |
| fird dil., or  |                                 | اء<br>احا      |   |                 | If Yes, Give Ye       | ear                  |                 |   | Yes 2                      | . X                    |                           |                       | -ul-dana                        | 1166              | Specify:           |                     |   |
| hours afte<br>'natural''<br>Examine  | d be                            |                | 5. Decedent's Education (Spe                                      | cify onl        |                       |                      |                 | 6a. Decedent<br>during mo               | s Usual O<br>st of worki   | ccupations in a life.  | DO NOT L                  | ina of w<br>use retir | ed)                             | 100               | . Kind of bo       | 3111600711          |   |
| 136<br>hin 72 h<br>ie.<br>than "r<br>edical E  | Completed                       |                | Elementary/Secondary (0-12) 12th                                  |                 | College               | (1-4 or 5            | +)              | Dis                                     | sabil:                     | ity                    |                           |                       |                                 | Ì                 | N                  | /A                  |   |
| 5-0036 iled within 72 Hygiene. Jother than 'the Medical  | 8                               |                | 7. Father's Name (First, Middle                                   | Last)           |                       |                      |                 |   |                            |                        | 8.Mother's                | Name                  | (First, Midd                    | e, Maid           | en Surname         | .)                  |   |
| 215-<br>215-<br>be filed<br>mtal Hyg<br>rked of  | 9                               |                |   |                 | y Shor                | rt Si                | ſ.              |   |                            |                        |                           | Jame                  | eylah                           | Jone              | es                 |                     |   |
| Z 2 6 2 2  | 1 0                             |                | a. Informant's Name/Relations                                     |                 |                       |                      |                 | 19b. Mailing                            | Address                    | (Street                | and Num                   | ber or R              | Rural Route                     | Number,           | City or Tow        | /n, State,          | , Zip Code)   |
| MD<br>d 2 she<br>lith and<br>n 27 is   | '                               | 1              | Marlene Kells   | /               | Step-n                | nothe                | er              |   |                            |                        |                           |                       | Balt:                           | Lmor              | e, Mai             | - City or           | nd 21225<br>Town, State                             |
| gges I and 2 should not of Health and N  | jj                              | 2              | Da. Method of Disposition  Burial 2 X Crematio                    | 3               | Removal               | from Sta             | ite cre         | ace of Dispos<br>ematory or oth         | ner place)                 |                        | 1                         | /                     |                                 |                   |                    |                     |   |
| MOI<br>Pages<br>ent of<br>int: 1   |                                 |                | Donation 5 Other S  | pecify:         |                       |                      | Bay             | view (                                  | _                          |                        |                           | _                     |                                 |                   |                    |                     | , Maryland  |
| Baltimore, permit. Pages 1 at Department of He Important: If ite   |                                 | 2              | 1. Si ure o Funeral Service                                       | Licen           | see                   | 1                    |                 |   | lame and A                 |                        |                           |                       | nce F                           | uner              | al Se              | rvic                | e, P.A.   |
| <b>60</b> 8.5 4.5  |                                 | 1              | 3a. Part . Enter the disease, o                                   | للا             | 02                    | de                   | the death F     | 4(                                      | OI K                       | tch<br>f dving.        | such as c                 | 1gnw<br>ardiac o      | r respirator                    | arrest,           | shock, or he       | eart                | y1and 21225<br>Approximate Interval                 |
| Physician<br>/Medica   |                                 | 2              | 3a. Part I. Enter the disease, o<br>failure. List only one cause  | e on ea         | ich line.             | V                    |                 |   |                            | , .,                   |                           |                       |                                 |                   |                    |                     | Between Onset and<br>Death                          |
| ≟xamine  |                                 |                | mmediate Cause (Final disease<br>or condition resulting in death) |                 | CompLi  Due to (or as |                      |                 | gunshot                                 | wouna                      |                        |                           |                       |                                 |                   |                    |                     |   |
|  |                                 | 1              |   | b.              | Duc to (o. a.         | s a como             |                 |   |                            |                        |                           |                       |                                 |                   |                    |                     |   |
|  |                                 | <b>- 1</b> .   | Sequentially list conditions, fany, leading to immediate          |                 | Due to (or a          | s a conse            | equence of):    | :                                       |                            |                        |                           |                       |                                 |                   |                    |                     |   |
|  |                                 | EΙ(            | cause. Enter Underlying Cause Disease or injury that initiated    | U.              | Due to (or a          | s a conse            | equence of)     | :                                       |                            |                        |                           |                       |                                 |                   |                    |                     |   |
| ated<br>d  | ansii                           |                | events resulting in death) Last                                   | d.              |                       |                      |                 |   |                            |                        |                           |                       |                                 |                   |                    |                     |   |
| exectian an  | 131 - II                        | <u> </u>       | X UNPENDED  |                 | AMENDE                | 27.28                | Ba−f. o         | erME,g87                                | 72. 10                     | /2/07                  | TT                        |                       |                                 |                   |                    |                     |   |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and   | ie pui                          | Medical        | F FEMALE:   |                 | 23c. If y∈            | es, outcor           | me of pregn     | ancv                                    |                            |                        |                           | 0.0000                | onci/                           |                   | 23d. Date of Month |                     | ry<br>Day Year                                      |
| Box 68760 death certificate bette ding physical to the attending physi | e as u                          |                | 3b. Was decedent pregnant in past 12 months?                      | tne             |                       | e birth<br>eanant at | t time of dea   | ====================================    | etal death                 |                        | Ectopi                    | c pregn               | ancy                            |                   | World              |                     | 50,   |
| Sox 687 death certific   | tor us                          | Physician      | 1 Yes 2 No 9 U  | nknowi          |                       | known                |                 | 2 0                                     | ther (Spe                  | city)_                 |                           |                       |                                 |                   |                    |                     |   |
| D. B<br>the de   | ched                            | <u> </u>       | Part II. Other significant cond                                   | itions          | contributin           | g to deat            | th but not re   | sulting in the                          | underlying                 | cause                  | given in P                | art I.                |                                 |                   |                    |                     | the cause of death?                                 |
| Division of Vital Records, P.O tal or Attending Physician: The law requires that tes after death.  31 Director: After this certificate has been signed by  | se det                          | 9              |   |                 |                       |                      |                 |   |                            |                        |                           |                       |                                 | SID TO            |                    |                     | bably 4 Unknown                                     |
| ds,<br>equir   | plio .                          | Completed      |   | _               |                       |                      |                 |   |                            |                        |                           |                       | i i                             | Was an<br>autopsy | 1                  | prior to            | utopsy findings available<br>completion of cause of |
| COF<br>s law s   | e 2 sh                          | 립              |   |                 |                       |                      |                 |   |                            |                        |                           |                       |                                 | performe<br>Yes 2 |                    | death?              |   |
| <b>tal Re</b> ction: The certificate   | or, pag                         |                | 25. Was case referred to media                                    | cal I           |                       |                      |                 |   |                            | 26.Plac                |                           | (Check                | k only one)                     |                   |                    |                     |   |
| /ital<br>sician  | funeral director, page 2 should | m              | examiner? 1 ✓ Yes 2 No  |                 | Hospital: 1           | Inpati               | ent 2           | ER/Outpatie                             | nt 3 [                     | AOC                    | Other <sub>4</sub>        | Nurs                  | ing Home                        |                   | esidence 6         |                     | er: Scene   |
| of \ing Phy  | neral                           | 의              | 27. Manner of Death   |                 | 28a. D                | ate of Inj           | jury<br>Year)   | 28b. Time of                            | Injury                     |                        | ury at Wor                | _                     | 28d. Des                        | cribe ho          | w injury occ       | urred               |   |
| On<br>endin<br>ath.  | the fu                          | 흵              |   | nding<br>estiga | Fnd                   | 8/4/2                | 2007            | FNd 7:0                                 | 05 pm                      |                        | Yes 2                     |                       | subj                            | ect v             | vas sho            | t_                  | Rural Route Number, City                            |
| ViSi<br>or Att<br>fter de  | in by                           | Ę              | 3 Suicide 6 Co  | uld no          | t be 28e. F           | Place of I           | injury - At ho  | ome, farm, str                          | eet, factor                | y, office              | building,                 | etc.                  |                                 |                   |                    |                     | G Baltimore, N                                      |
| Division  To the Hospital or Attent within 24 hours after death To the Funeral Director:   | completely filled in by the     | Certification: | 4 Homicide  | termin          | , -,                  |                      | reside          | nce                                     |                            |                        |                           |                       |                                 |                   |                    |                     |   |
| e Hos<br>124 hc<br>e Fun   | etely                           |                | 1 Direction, or my  | Physic          | cian: To the          | best of r            | my knowledg     | ge, death occ                           | urred at th<br>ation, in m | e time, i<br>ny opinio | date and p<br>on, death c | olace, ar<br>occurred | nd due to the<br>d at the time  | , date ar         | nd place, an       | d due to            | the cause(s)  |
| To the<br>within To the  | compl                           | Medical        |   |                 | and manr              | er stated            | d               | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                            |                        | se numbe                  |                       |                                 |                   | 29d. Date s        | igned (A            | fonth, Day, Year)                                   |
|  |                                 | Σ              | 29b. Signature and title of cert                                  |                 | 1 1                   |                      |                 |   | -                          |                        | M.E.                      |                       |                                 |                   | August 5           | 5, 2007             | •   |
|  |                                 |                | Donna m   |                 |                       |                      | dagth /li-      | 232)                                    |                            | -                      |                           |                       |                                 |                   |                    |                     |   |
|  |                                 |                | 30. Name and address of pers<br>Donna M. Vincenti,                |                 | completed<br>Assista  | cause of<br>nt Med   | ical Exar       | niner 1                                 | 11 Penn                    | Stree                  | et, Baltir                | nore,                 | MD 2120                         | 1                 |                    |                     |   |
|  |                                 |                |   |                 | 33                    |                      | rar's Signati   |   | ale                        |                        |                           |                       |                                 |                   |                    |                     |   |
|  | ગ                               | ate            | 31. Date filed (Month Pay Ye.                                     | 5 2             | 007                   | LEN                  | W 1             |   | and the same               |                        |                           |                       |                                 |                   |                    |                     |   |

|  | 1  | For State of Maryland / Department of Health and Maryland / Department / D | ена пу                                  | Reg. No.                                | 2007                                     | 26192  |
|--|----|--|---|---|--|--|
| Physician<br>/Medical  | 1  | 1. Decedent's Name (First, Middle, Last)  ROSE JUANITA SAWYER  | 2. Date of De<br>Month                  | eath<br>Day                             | Year 2,2007                              | 3. Time of Death 6:28 a <sup>M</sup>               |
| Examiner   | 4  | 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death   |   |   | County of Death                          |  |
|  |    | ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS  |   |   |  | NDEL CO.   |
| Funeral<br>Director  |    | 5. Social Security Number 6. Sex 1 $\square$ M 2 $\square$ F 8 3 Yrs.  6. Sex 1 $\square$ M 2 $\square$ F 8 3 Yrs.  6. Sex 1 $\square$ M 2 $\square$ F 8 3 Yrs.  6. Sex 1 $\square$ Months Days Hours Min.   | 8. Date of Bi<br>(Month, Di<br>3 – 13 – | 1924                                    | 9. Birthp.<br>Cour<br>VIR                | lace (State or Foreign<br>htry)<br>GINIA           |
| at   | 1  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |   |   | 1  | 0d. Inside City Limits                             |
| tiffied ctor   |    | MD ANNE ARUNDEL SHADY SIDE   |   |   |  | 1X Yes 2 No  |
| or 28a-f st<br>be notified<br>Director   | 1  | 10e. Street and Number 10f. Zip Code   |   |   | en of What Cour                          | ntry?  |
| s 23a<br>nust  | -  | 1506 TERRELL ROAD 20764  | ooifu Voo or N                          |   | S.A.                                     | an Indian  |
| Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director | ١. | 11. Marital Status  1 □ Never Married  1 □ Never Married  3 □ Widowed 4 ☒ Divorced  1 □ Ves 2 ☒ No If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Sprif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:  1 □ Yes 2 ☒ No Specify:   | Rican, etc.)                            |   | Black, White,                            |  |
| ygiene.  ter than "natura"  t, the Medical E   | Ĺ  | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)   | ing                                     | 16b. Kin                                | d of Business/In                         | dustry   |
| giene.   |    | 1 2 College (1-4or 5+) ADMINISTRATIVE ASSIS  | STANT                                   |   | ERAL G                                   | OV'T.  |
| d othe   |    | 17. Father's Name (First, Middle, Last)  18. Mother's Name  THOSE  | e (First, Middle                        | _                                       |  |  |
| Ment<br>larked<br>latic e  | -  | HENRY HENSON LUCY  |   | PINK                                    |  |  |
| 7 is m<br>7 is m<br>raum   |    | 19a. Informant's Name/Relationship (Type. Print)  ZEELA DELANEY - DAUGHTER  19b. Mailing Address (Street and Number or Run  ZEELA DELANEY - DAUGHTER  1506 TERRELL ROAD.   |   |   |  |  |
| Healt<br>em 2<br>other   | 12 | 20a Method of Disposition 20b. Place of Disposition (Name of   | , SAAL<br>Date                          |   | cation - City or To                      |  |
| tment of<br>tant: If it  |    | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  HARMONY MEM. PARK 08—  |   |   |  | MARYLAND   |
| Depal<br>Impol<br>any ir   |    | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility ROI  108 WEST NORTH  |   |   |  |  |
|  |    | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only on cause on each line.   | or respiratory                          | arrest,                                 |  | Approximate<br>Interval Between<br>Onsevand Death  |
| hysician   | ١  | Immediate Cause (Final disease or condition a. Condition and the condition a.  |   |   |  | Onsevant Death                                     |
| /Medical<br>xaminer  | 1  | Due to (or as a consequence or):   |   |   |  |  |
| sit sit  |    | Sequentially list conditions, if any, leading to immediate cause. Enter United Mark Cause (Disease or injury that initiated events cause.  |   |   |  |  |
| in and rial-transit  |    | C  |   |   |  |  |
| g physician and as the burial-transit  |    | d  |   |   |  |  |
| To the Funeral Director: After this certificate has been signed by the attending prompletely filledlin by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Med                       |    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ Horizonth September 12 months of death September 12 months of death September 13 ☐ Compare 14 ☐ Pregnant at time of death September 14 ☐ Compare 14 ☐ Co  |   | 2                                       | 23d. Date of deliv                       | ery<br>Day Year                                    |
| an signed by uld be deta   |    | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   | se contribute to t                       | he cause of death?<br>bably 4  □Unknown            |
| cate has been single page 2 should   | -  |  | 24a. Wa<br>aut<br>per<br>1□ Yes         | opsy<br>formed?                         | 24b. Were autoprior to condeath? 1 □ Yes | opsy findings available ompletion of cause of 2 No |
| Sertific<br>ector,   |    | 25. Was case referred to medical examiner?  Hospital: Hospital: Other: Other: Other:   |   |   |  |  |
| this call dir  | -  | 1 ☐ Yes 2 ☐ No   | ome 5 Res                               |   | Other (Special occurred)                 | fy)  |
| After<br>fune  |    | 1 Netural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No   |   | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | , 000000                                 |  |
| rs after death. all Director: After ledlin by the funer.   |    | Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   |   | (Street and<br>own, State)              |  | al Route Number,                                   |
| in 24 hours<br>he Funeral<br>pletely filled  |    | 29a. Certifier (Check only one)  Check only one)   |   |   |  |  |
| vithin<br>To th<br>comp  |    | 29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number  |   | _                                       | e signed (Month                          |  |
| T  |    | 30. Name and address of person who empleted cause of death (Item 23a) (Type, Print)  Con J. Source 2(08), 1) and Driving   |   |   |  |  |
| State  |    | 31. Date filed (Month, Day, Year)  AUG 1 5 2007  32 Registrar's Signature  |   |   |  |  |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day August 14 2007 **Physician** Simmerer Sue 10:45 A<sup>M</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Anne Arundel County Pasadena 2947 Golden Fleece Drive Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 F Months Days Hours Yrs. 19,1946 Indiana 61 Director 265-68-8885 Jan. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b, County 1 □Yes 2 No Directo Marvland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21122 2947 Golden Fleece Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland 12 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tarczueski ပ္ Stella Francis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2947 Golden Fleece Drive Pasadena, Maryland 21122 Thomas J. Simmerer (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crownsyille V.A. Cem: 08/17/07 Crownsville Marvland <sup>22. Name and Address of Facility</sup> McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryla 21. Signature of Fureral Service Licensee Maryland 21122 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, skock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (or as a conse ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 3 Probably 4 Unknown 2 | No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death.

Director: / 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 24 hours after te Funeral Dire pletely filled in b Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the Fun completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D39505 Markan 305 Hospital M. Glan Burnie, MD. 21061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. egistrar's Signature State Registrar

Division or Vital Records, P.O. Box 68760,

funeral director, page 2 should Certification: To After this 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No М 2 Accident death. after death the 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral D completely filled i Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Clearly St POWSON MD ZIZO HYDRUES wo 6701 32. Régistrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Amend #8, per FH, 88/1, 9/13/07 The State of Maryland / Department of Health and Mental Hygiene | | | | | Amend #7,8,perFH, G871, 9/11/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1121A Month Year 10-40P 2007 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 16 sans Baltimore fr Under 24 Hrs. 8. Date and If Under 1 7. Age (In yrs. last birthday) 8364 10 M 21XF Days Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ates 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1□ Yes 2 Specify Black Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Washington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) Kesville alvin McMichae 20b. Place of Disposition (Name of cernetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 P 3 Removal from State 21. Signature of Funeral Service License 1639 Ni Broadway And 1. Soler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tyes 2 0 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

Examiner

Funeral

Director

item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or iter any Injury or other traumatic event. It is Mertical Exercises.

Baltimore, Maryland 21215-0020

death with the Maryland

/Medical

Director

by Funeral

Completed

Be

ဥ

Examiner Physician/Medical þ Completed Be 27. Manner of Death

ng physician and as the burial-transit Medical Certification: To

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fun. State

the attending physician

4 Homicide (Check only

29b. Signature and title of certifier

1 Yes 2 No

1 Natural 2 Accident

3 Suicide

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

Hospital: 1 ☐ Inpatient

2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

Other:

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

lacem 70 tun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

50

31. Date filed (Month, Day, Year) AUG 15 2007

Registrar

|             |   |                | For<br>State<br>Registrar   | State of Ma  | arylan             |                                 |                                |                       | lealth a<br>Death          | and Me                    |   | giene<br>Reg. No.          | 007                           | 2619   |      |
|-------------|---|----------------|---|--|--------------------|---------------------------------|--------------------------------|-----------------------|----------------------------|---------------------------|---|----------------------------|-------------------------------|--|------|
| ٠           | Physici   | an :           | 1. Decedent's Name (First, Middle, Las<br>Harvey G. Ta  |  |                    |                                 |                                |                       |                            | 1                         | 2. Date of De                           |                            | . 2 Year                      | 3. Time of Deat                                    |      |
| **          | /Medic  |                | 4a. Facility Name (If not institution, give   |  |                    |                                 | 4b. City                       | , Town, or            | r Location o               | of Death                  | AUGUS                                   |                            | ounty of Dea                  | th   | IVI  |
|             |   |                | Saint Joseph  |  |                    |                                 |                                |                       |                            | WSOT                      | 1                                       |                            | Balt                          | timore   |      |
| A.          | Funeral<br>Director   |                | 5. Social Security Number 6. Se 218-36-2968   | ex<br>FM 2□F 7.Ag  | e (In yrs. I<br>68 | ast birthday)<br>Yrs.           | Months Months                  | Days                  | If Under 2<br>Hours        | Min.                      | 8. Date of Bir<br>(Month, Da<br>OCt • 1 | 19 Year)                   | 9. Bir<br>38 MA               | thplace (State or Ford<br>ountry)<br>aryland       | eign |
| ì           | and w   |                | Usual Residence of Decedent  10a. State 10b. County   |  | 10c City           | , Town or Lo                    | cation                         |                       |                            |                           |   |                            |                               | 10d. Inside City Lin                               | nito |
|             | Maryla<br>-f sho  | to             | MD Baltin   | nore   | loc. only          | Ess                             |                                |                       |                            |                           |   |                            |                               | 1 Tyes 2   |      |
|             | ith the<br>or 28a   | Director       | 10e. Street and Number  |  | 1                  |                                 | 10f. Z                         | ip Code               |                            |                           |   | 10g. Citizer               | n of What Co                  | ountry?  |      |
|             | sath w  |                | 504 North Essex   |  |                    | 5 140.1                         | Man Dan                        |                       | 221                        | -1-0 (0                   | '4 - V 1                                | USA                        | Daga Ama                      | rices Indian                                       |      |
| 980         | be filed within 72 hours after death with the Maryland ital Hygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 12. Was Decedent Armed Forces?  1 ☐ Yes 2 XI If Yes, Give Year or Dates: |                    |                                 | was Dec<br>fYes, sp<br>1 ☐ Yes |                       | Specify:                   | gin? (Spec<br>i, Puerto R | ify Yes or No<br>ican, etc.)            |                            | Black, Whit                   |  |      |
| 2-0036      | 72 ho<br>"natur<br>di al f  | eted           | 15. Decedent's Ed<br>(Specify only highest grad   | ucation<br>de completed)   |                    | 16a. Deced                      | lent's Us<br>kind of w         | ual Occup             | ation<br>during most       | t of working              | 7                                       | 16b. Kind                  | of Business                   | /Industry  |      |
| 121         | within<br>iene.<br>than '   | Completed      | Elementary/Secondary (0-12) 12th  | College (1-4or 5   | 5+)                |                                 |                                | use retired<br>Visi   |                            | ·                         |   | Car                        | ling                          | National   |      |
| Maryland 21 | 0 = 0 \$  | Be C           | 17. Father's Name (First, Middle, Last)   |  |                    |                                 |                                |                       | 18. Mothe                  | ,                         | First, Middle,                          |                            | ırname)                       |  |      |
| <u> </u>    | should be<br>and Mental<br>marked o   | 은              | Elroy Tankers   |  |                    | T 401 11 11                     |                                |                       |                            |                           | Becke                                   |                            |                               |  |      |
|             | an s  |                | 19a. Informant's Name/Relationship (7)  Kay Tankersley  |  |                    | 1                               |                                |                       |                            |                           | Route Numb<br>enue                      |                            |                               | zip Code)<br>- MD 2122                             | 1    |
| ore,        |   |                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐   | Romoval from State   | 20b. PI            | lace of Dispo<br>emetery, crer  | sition (Na                     | ame of<br>other plac  | ce)                        | Da                        | te                                      |                            |                               | Town, State  | _    |
| altimore,   | t. Pages<br>tment of I<br>tant: If Ik   |                | 4 ☐ Donation 5 ☐ Other (Specify   | )  | Oa.                | k Law                           | n C                            | emet                  | ery                        |                           | /07                                     | Balt                       | timor                         | e MD   |      |
| Ва          | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.  |                | 21. Signature of Funeral Service Licens   | der  | A                  |                                 | Coi                            | nnel                  | ss of Facility  1 y F1     | uner                      | al Ho                                   | me of                      |                               | to. MD<br>ex 21221                                 |      |
|             |   |                | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only of<br>Immediate Cause (Final   | lications that cause to<br>one cause on each lin                         | e death            | . Do not ente                   | er the mo                      | de of dyin            | g, such as                 | cardiac or                | respiratory a                           | rrest,                     |                               | Approximate<br>Interval Between<br>Onset and Death |      |
| ,           | Physician<br>/Medical   |                | disease or condition resulting in death)  | a. SEPTIC<br>Due to (or as   |                    |                                 |                                | _                     |                            |                           |   |                            |                               |  |      |
|             | Examiner  |                | Sequentially list conditions,   | b. MYOCAF  |                    |                                 | ARCI                           | LION                  |                            |                           |   |                            |                               |  |      |
| 1           | nsit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | c. SEVERE  |                    | •                               | e a r                          | מדי ד רזו             | MYOPA                      | THV                       |   |                            |                               |  |      |
| o<br>o      | ficate be executed<br>physician and<br>sthe burial-transit  |                | that initiated events resulting in death) Last  | Due to (or as  |                    |                                 | LPHI                           | (T) I (I)             | HIGH                       | 71111                     |   |                            |                               |  |      |
| 68/60,      | cate be   | edical         |   | d  |                    |                                 |                                |                       |                            |                           |   |                            | -                             |  |      |
| POX 6       |   |                | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome   |                    |                                 |                                |                       |                            |                           |   | 230                        | d. Date of de                 | livery   |      |
| S<br>E      | 0 0 0   | Physician/M    | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 1 □ Live birth<br>4 □ Pregnant at<br>9 □ Unknown                         |                    |                                 | Ectopic <br> Other (s          | pregnancy<br>specify) |                            |                           |   |                            | Month                         | Day Year   |      |
| Ž.          | requires that the<br>een signed by the  |                | Part II. Other significant conditions co  | ontributing to death by  | ut not resu        | Iting in the ur                 | nderlying                      | cause give            | en in Part I.              |                           | 23e. Did t                              | obacco use                 | contribute to                 | o the cause of death?                              | ?    |
| ecords      | w requires that<br>been signed be<br>should be deta   | ed by          | END STAGE REN   | AL DISEAS  | E                  |                                 |                                |                       |                            |                           | 10,                                     | Yes 2 <b>X</b> 1           | No 3□P                        | robably 4 Unkno                                    | wn   |
| ပ္ပ         | e law re<br>has bed<br>je 2 sho   | Completed      |   |  |                    |                                 |                                | <u>-</u>              |                            |                           | 24a. Was                                | osv                        |                               | utopsy findings availa<br>completion of cause      |      |
| <u>a</u>    | ician: The<br>certificate ha  |                | OF Management and a section of  |  |                    |                                 |                                |                       |                            |                           | perfo<br>1⊟ Yes                         | rmed?<br>2 <b>X</b> I No   | death?<br>1 ☐ Yes             | - A  |      |
| VItal       | ysicia<br>is certi<br>directo   | To Be          | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No   | Hospital: 1 npatie   | ent 2 □ E          | ER/Outpatien                    | t 3 🗆 D                        | OA Othe               | or:                        |                           | Check only o                            |                            | Other (Spe                    | acifu)   |      |
| n 0         | ng Phy<br>ofter thi   |                | 27. Manner of Death  1 Natural 5 □ Pending  | 28a. Date of Injur<br>(Month, Day  | ry                 | 28b. Time of<br>Injury          |                                | 28c. Injun<br>Work    |                            |                           | d. Describe I                           |                            |                               |  |      |
| UNISION     | Vttendi<br>death.<br>ctor: A<br>y the fu  | Certification: | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be   | 28e. Place of inju   | ırv - At hoi       | me farm stre                    | M et facto                     |                       | Yes 2 ☐ N                  |                           | of Location (                           | Street and N               | lumber or Pi                  | ural Route Number.                                 |      |
| 2           | s after al Dire   | Sertif         | 4 ☐ Homicide determined   | building, etc  | c. (Specify        | )                               | , , , , ,                      | .,, 000               |                            | 20                        | City or Tov                             |                            | varnoer or m                  | urai rroute Number,                                |      |
|             | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,        | edical (       | 29a. Certifier 1 Certifying Phy<br>(Check only one) 2 Medical Exam  | vsician: To the best of<br>liner: On the basis of<br>and manner sta      | f examinat         | vledge, death<br>ion and/or inv | occurre<br>vestigatio          | d at the tin          | ne, date an<br>pinion, dea | d place, ar<br>th occurre | nd due to the<br>d at the time,         | cause(s) ar<br>date and pl | nd manner as<br>lace, and due | s stated.<br>e to the cause(s)                     |      |
|             | To th<br>Within<br>Compl  | ₹ P            | 29b. Signature and title of certifier   | 9  | 1/1                | 6                               | 29                             | c. License            | number                     |                           |   | 29d. Date s                | signed (Mont                  | th, Day, Year)                                     |      |
| 1           |   |                | limathe   | sow  | 11/                | iv.                             |                                | D24                   | 034                        |                           |   | 8                          | 113/0                         | 07   |      |
|             | 10  |                | 30. Name and address of person who c  |  |                    |                                 |                                | T 111-                | 77 (21.1)                  | CON                       | MARY                                    | 1 ONES                     | 2120                          | 14   |      |
|             | Sta   | te             | 31. Date filed (Month, Day, Year)   | 32. Regustra   |                    | OSLER<br>ure                    | DR                             | IVE                   |                            | <u> </u>                  | 171Hrt                                  | L-PHYL/                    | L., J. L., 40                 | 4  |      |
|             | Registra  | ar             | THAT E  | THAT ME.   | 0.000              | Fis A                           | <b>和海</b> 里                    |                       |                            |                           |   |                            |                               |  |      |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 26197

|  |               | 1- For State<br>Registrar  |                                     | Certif                         | icate of                        | Death                                 |                    |             | Re                 | eg. No.                     | 001 6012                        |
|--|---------------|--|-------------------------------------|--------------------------------|---------------------------------|---------------------------------------|--------------------|-------------|--------------------|-----------------------------|---------------------------------|
| Physici  |               | Decedent's Name (First, Middle)  | e,Last)                             |                                |                                 |                                       |                    | . 2.        | Date of Dea        | th                          | 3. Time of Death                |
| Medical Exam   | iner          | SHIRLEY  | ANN                                 | TR                             | NAMTO                           |                                       |                    |             | Month<br>August 10 | Day Yea<br>), 2007          | 0716 hrs                        |
|  |               | 4a. Facility Name (if not institution  | =                                   | umber)                         | 4                               | b. City, Town, o                      | r Location o       | of Death    |                    | 4c. County of               | of Death                        |
|  |               | 8610 Snowden River   | Parkway                             |                                |                                 | Columbia                              |                    |             |                    | Howard                      |                                 |
| Funeral  |               | 5. Social Security Number  | 6. Sex                              | 7. Age (In yrs. last           | birthday)                       | If Under 1 Ye                         | ar If Unde         | er 24Hrs.   | 8. Date of Bir     | th (MM/DD/YYYY              | 9. Birthplace (State or Foreign |
| Director   |               | 153-30-7421  | 1 M 2XF                             | 7                              | O yrs.                          | Months Da                             | ys Hours           | Min.        | 12-28              | 3-1936                      | ORANGE, NJ                      |
|  |               | Usual Residence of Decedent  |                                     |                                |                                 |                                       |                    |             |                    |                             |                                 |
| any  |               | 10a. State 10b. County   |                                     | 10c. City, To                  | wn or Location                  | on                                    |                    | -           |                    |                             | 10d. Inside City Limits         |
| d<br>wor   |               | N.C.   |                                     | CHA                            | RLOTI                           | ਾਜ਼ਾ                                  |                    |             |                    |                             | 1 Yes 2 X No                    |
| Maryland<br>28a-f show any<br>d at nre   | cto           | 10e, Street and Number   |                                     | CIII                           | ICDO11                          | 10f. Zip Code                         |                    |             | - 14               | 0g. Citizen of Wh           |                                 |
| e Mai<br>or 28   | Director      |  | CON COLL                            | ъ                              |                                 | ,                                     | 1 5                |             |                    | U.S.A.                      | ·                               |
| 215-0036 be filed within 72 hours after death with the Maryland nual Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at one   |               | 9611 CALLI   |                                     |                                |                                 | 2821                                  |                    |             |                    |                             |                                 |
| th wi<br>ems<br>t be   | Funeral       | 11. Marital Status 1 Never Married 2 | 12. Was Dec                         | cedent Ever in U.S. orces?     |                                 | Decedent of H<br>s, specify Cuba      |                    |             |                    | - 14. Race<br>White         | - American Indian, Black,       |
| r dea<br>or it   | Fur           |  | 1 Yes                               | 2 X No                         |                                 | · ·                                   |                    |             | ,                  |                             |                                 |
| s afte<br>ral",  | by            |  | orced If Yes, Give Yes<br>or Dates: |                                |                                 | Yes 2 X N                             |                    |             |                    | Specify:                    | BLACK                           |
| hour:<br>natu<br>Exan  | pa            | 15. Decedent's Education (Spe-   |                                     |                                |                                 | 's Usual Occupa<br>st of working life |                    |             |                    | 16b. Kind of Bus            | siness/Industry                 |
| 16<br>n 72<br>isan "   | ompleted      | Elementary/Secondary (0-12)  | College (                           | 1-4 or 5+)                     | _                               | _                                     |                    |             | ''                 | CMAME                       | EADM                            |
| 003<br>withii<br>iene.   | Щ             |  | 2                                   |                                | TNSC                            | JRANCE                                |                    |             |                    |                             | FARM                            |
| 5-C  | C             | 17. Father's Name (First, Middle,  | Last)                               |                                |                                 |                                       |                    |             | irst, Middle, I    | Maiden Surname)             |                                 |
| 21215-0036 wild be filed within 72 hours afte Mental Hygiene. narked other than "natural", cevent, the Medical Examiner  | Be            | ODELL  |                                     | BROWN                          |                                 |                                       |                    | TIE         | М.                 | JON                         |                                 |
| D 21<br>should<br>and Mer<br>7 is man  | မ             | 19a. Informant's Name/Relations  | ,                                   |                                |                                 |                                       |                    |             |                    |                             | n, State, Zip Code)             |
| Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health, and M Important: If item 27 is m injury or other traumatic.  |               | QUINN P. WIL   | LIAMS -                             |                                |                                 |                                       |                    |             |                    |                             | NC 28215                        |
| S 1 ar   |               | 20a. Method of Disposition  1 X Burial 2 Cremation   | 3 Removal fr                        | 20b. Plac                      | ce of Disposit<br>natory or oth | tion (Name of ce<br>er place)         | emetery,           |             | Date               | 20c. Location -             | City or Town, State             |
| Page<br>lent o   |               | 4 Donation 5 Other Sp  |                                     |                                | •                               | , ,                                   | CEM                | 08-         | 16-07              | EAST                        | HANOVER, NJ                     |
| Baltimore,<br>permit. Pages 1 a<br>Department of He<br>Important: If ite   |               | 21. Signature of Funeral Service   |                                     | 111311                         |                                 |                                       |                    |             |                    | YLOR,                       |                                 |
| <b>ស</b> ្ត្រី គ្ន   | K 19          | 15 C. Sh.  | 2005                                |                                | 108                             | WEST                                  | NORT               | 'H AV       | Έ., Ε              | BALTIMO                     | RE, MD 21201                    |
| Physician  |               | 23a. Part I. Enter the disease, or   | complications that of               | aused the death. Do            |                                 |                                       |                    |             |                    |                             |                                 |
| /Medical   |               | failure. List only one cause   | 11                                  | ve Atherosclero                | tic Cardio                      | was cular Di                          | 50250              |             |                    |                             | Between Onset and<br>Death      |
| Examiner   |               | Immediate Cause (Final disease<br>or condition resulting in death)   |                                     | consequence of):               | ouc Cardic                      | vasculai Di                           | 36436              |             |                    |                             |                                 |
|  |               | Sequentially list conditions,  | b.                                  |                                |                                 |                                       |                    |             |                    |                             |                                 |
|  | лег           | if any, leading to immediate   | Due to (or as a                     | consequence of):               |                                 |                                       |                    |             |                    |                             |                                 |
|  | Examiner      | cause. Enter Underlying Cause (Disease or injury that initiated  | C                                   |                                |                                 |                                       |                    |             |                    |                             |                                 |
| ed usit  | Exa           | events resulting in death) Last  | Due to (or as a                     | consequence of):               |                                 |                                       |                    |             |                    |                             |                                 |
| executed<br>an and<br>al - transit   | g             | UNPENDED   | d                                   |                                |                                 |                                       |                    |             |                    |                             |                                 |
| 760, icate be ex physician the burial  | n/Medical     |  | AMENDED                             |                                |                                 |                                       |                    |             |                    |                             |                                 |
| 8760, tificate be ng physic as the bur   | Μ             | IF FEMALE:<br>23b. Was decedent pregnant in th   |                                     | outcome of pregnan             |                                 |                                       |                    |             |                    | 23d. Date of                | ,                               |
| certi  | iai           | past 12 months?  |                                     | oirth<br>nant at time of death | 2 Feta                          |                                       | Ectopic            | c pregnancy | у                  | Month                       | Day Year                        |
| Box<br>e death c<br>the atten  | ysi           | 1 Yes 2 No 9 🗸 Unk   |                                     |                                | ⊃ Oth                           | er (Specify)                          |                    |             |                    |                             |                                 |
| that the death certificated by the attending detached for use as   | Physiciar     | Part II. Other significant conditi   | ons contributing to                 | o death but not resul          | ting in the ur                  | derlying cause                        | given in Pa        | ırt I.      | 23e. Did to        | bacco use contri            | bute to the cause of death?     |
| ords, P.C. w requires that is been signed be   | Ş             |  | _                                   |                                | Ū                               | , ,                                   |                    |             | 1 Yes              |                             | Probably 4 V Unknown            |
| dS,<br>equire  | Completed     |  |                                     |                                |                                 |                                       |                    |             | 24a. Was a         |                             | Vere autopsy findings available |
| aw re  | 용             |  |                                     |                                |                                 |                                       |                    | ····        | autop              | sy pi                       | rior to completion of cause of  |
| Rec<br>The I   | è             |  |                                     |                                |                                 |                                       |                    |             | 1 Yes              | rmed? de<br>2 <b>✓</b> No 1 | eath?<br>Yes 2 X No             |
| tal Recions: The certificate ector, page   | Be            | 25. Was case referred to medical   |                                     |                                |                                 | 26.Plac                               | e of Death (       | (Check only | y one)             |                             | ,                               |
| of Vital Records, ng Physician: The law require the this certificate has been si meral director, page 2 should b   | ToB           | examiner?  | Hospital: 1                         | Inpatient 2 ER                 | /Outpatient                     | 3 DOA                                 | Other <sub>4</sub> | Nursing F   | lome 5             | Residence 6                 | Other: Scene                    |
| of Vi<br>ing Physi<br>After this<br>funeral dir  |               | 27. Manner of Death  | 28a. Date                           | of Injury 28<br>, Day,Year)    | b. Time of In                   | ury 28c. Inju                         | ıry at Work        | ? 28        | d. Describe h      | now injury occurre          | ed                              |
| Division tal or Attendi rs after death. at Director: A   | 恴             | 1 Natural 5 Pend   | ing                                 | , Day, real)                   |                                 | 1_                                    | Yes 2              | No          |                    |                             |                                 |
| ivision or Attendather death Director:   | 밀             |  | tigation 28e. Plac                  | e of Injury - At home          | , farm, street                  | , factory, office                     | building, etc      | c. 28       | f. Location (S     | Street and Numbe            | r or Rural Route Number, City   |
| Div  | ertification: |  | mined (Specify)                     |                                |                                 |                                       |                    | - 1         | or Town, S         |                             | ,,                              |
| Lospi<br>4 hou<br>iunei  | O             | 20a Cartifiar  | vsician. To the hes                 | at of my knowledge, o          | death accurr                    | ad at the time d                      | ate and nia        | oo and du   | o to the saus      | o/o) and manner             | an stated                       |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burit | Medical       | (Check only one) 1 Certifying Pri  | niner:On the basis                  | of examination and/o           |                                 |                                       |                    |             |                    |                             |                                 |
| To To  | Mec           | 29b. Signature and title of certifie   | and manner s                        |                                |                                 | 29c. Licens                           |                    |             |                    |                             | ed (Month, Day, Year)           |
|  | -             | 1101 . 01  | 0 1/1                               | 00 100                         | 1/4                             |                                       | M.E.               |             |                    | Į.                          |                                 |
|  |               | W C  | - 14-6                              | rul                            |                                 | 0.0.                                  | IVI. C.            |             |                    | August 13,                  | 2001                            |
| 1191   |               | 30. Name and address of person   |                                     |                                | ,                               |                                       |                    | 04001       |                    |                             | 9                               |
| 71   |               |  | sistant Medical                     | - 69                           |                                 | treet, Baltim                         | ore, MD            | 21201       |                    |                             |                                 |
| St<br>Regist   |               | 31. Date filed (Month, Day, Year)  | 5 2007 32. Re                       | strar's Signature              | E So                            | ander                                 |                    |             |                    |                             |                                 |
| regist   | uell          |  | 0 2001                              |                                | -/                              |                                       |                    |             |                    |                             |                                 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** TARBUTTON Month Day Year FRANCES B. 2:45 AM AUGUST 2007 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR HOSPITAL N/A BALTIMORE 8. Date of Birth (Month, Day, Dec. 19, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 💆 F Rhode Island 89 Yrs. 213-64-2609 **Director** Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 XYes 2 □ No Director Maryland N/A Brooklyn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Eighth Street 21225 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give' Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 2 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Housewife Home Department of Health and Mental Hygie Important: If item 27 is marked other than any injury or other traument. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Burrel1 Stanley Lula Karnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Son) William R. Tarbutton 18 Sunset Drive, Gettysburg, Pennsylvania 17325 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐Removal from State Bayview Crematory 08-13-07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home P.A.
237 East Patapsco Ave.Baltimore, Maryland 21225 21. Signature of Juneral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, chock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART FAILURE **Physician** CONGESTIVE /Medical Due to (or as a consequence of): Examiner Gagueritiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Physician/Medical aftending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Vear 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director; After th | completely filled in by the funeral

State Registrar PHYSICIAN

29c. License number

29d. Date signed (Month, Day, Year)

RES 000

AUGUS7

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHNA BEBU, 300/ SDUTH HANOVER STREET, BACTIMORE, MD 2/225

31. Date filed (Month, Day, Year) AUG 1 5 2007

29b. Signature and title of certifier



7. Age (In yrs. last birthday)

10c. City, Town or Location

77

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

Union Bridge

2. Date of Death

Day

4c. County of Death

14. Race - American Indian, Black, White, etc.

Carroll

August 10, 2007

8. Date of Birth (Month, Day, Year) Sept. 7, 1929

Month

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2XX No

Maryland

7:40 P M

|                                | × -   | 5                 | Maryland  Carrol  | L                                    | Un                       | ion Br                              | idge                            | 3                                       |                                       |                            |                            |                 |               |
|--------------------------------|---|-------------------|---|--------------------------------------|--------------------------|-------------------------------------|---------------------------------|---|---------------------------------------|----------------------------|----------------------------|-----------------|---------------|
|                                | E 28  | Directo           | 10e. Street and Number  |                                      |                          |                                     | 10f. Zi                         | ip Code                                 |                                       |                            | 10g. Citiz                 | zen of What C   | Country?      |
|                                | th witi   | a D               | 328 Clear Ridge 1   | Road                                 |                          |                                     |                                 | 2179                                    | 1                                     |                            | Unit                       | ed Sta          | ites          |
|                                | dea   | Funerai           | 11. Marital Status  | 12. Was Decedent E<br>Armed Forces?  | ver in U.S               | . 13. W                             | as Dece                         | edent of H                              | spanic Origin? (S<br>n, Mexican, Puer | pecify Yes or I            | No- 1                      | 14. Race - Am   |               |
| 9                              | after<br>or it  |                   | 1 Never Married 2 Married   |                                      | lo                       |                                     |                                 | 2 <b>X</b> No                           |                                       | to moan, etc.,             |                            | Black, Wh       |               |
| 8                              | raf.  | d by              | 3 ∰Widowed 4 □ Divorced   | Year or Dates:                       |                          | '                                   | 7 162                           | 222110                                  | Specify:                              |                            | -                          | Specify: Wh     | ITLE          |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the M Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-filmportant: of items 23a or 28a-filmportant; or other traumatic event, it a Medical Evalu, at must be invitible any folury or other traumatic event, it a Medical Evalu, at must be invitible. | Completed         | 15. Decedent's (Specify only highest of   | rade completed)                      |                          | 16a. Decede<br>(Give ki<br>life. DC | nt's Usu<br>nd of wo<br>D NOT L | ual Occupa<br>ork done d<br>use retired | ation<br>during most of wo<br>)       | rking                      | 16b. Kin                   | nd of Business  | s/Indust      |
| 212                            | with<br>iene  | E                 | Elementary/Secondary (0-12)   | College (1-4or 5-                    | +)                       | Dairy                               | Far                             | mer                                     |                                       |                            | Ag                         | ricult          | ure           |
| D                              | tilec<br>Hyg<br>othe  | BeC               | 17. Father's Name (First, Middle, La.   | st)                                  |                          |                                     |                                 |   | 18. Mother's Na                       | ne (First, Midd            |                            |                 |               |
| ılan                           | Aental<br>Aental<br>rked<br>ric ev  | P P               | William Henry Ma:   | ln                                   |                          |                                     |                                 |   | Flora Ca                              | rpenter                    | 5                          |                 |               |
| ar <sub>Z</sub>                | shoi<br>and h   |                   | 19a. Informant's Name/Relationship  | (Type, Print)                        | 68610                    | 19b. Mailing                        | Addres                          | s (Street a                             | and Number or R                       | ural Route Num             | ber, City or               | Town, State.    | Zip Cod       |
| Σ                              | nd 2<br>alth a<br>27 li<br>r tra  |                   | Lynne Parrish / I   | Daughter                             |                          | 328 Cl                              | ear                             | Ridg                                    | e Rd. Un                              | ion Bri                    | idge,                      | MD 217          | 91            |
| ē,                             | s 1 a<br>f He<br>item<br>oths   |                   | 20a. Method of Disposition  |                                      | 20b. Pla                 | ice of Disposit                     | ion (Na                         | ame of                                  | a) A                                  | Date                       | 20c. Loc                   | cation - City o | r Town,       |
| 5                              | Page<br>ent c<br>nt: if<br>ry or  |                   | 1 ⊠ Burial 2 ☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Soe   |                                      |                          | Rest                                |                                 |   |                                       | st 14,                     | Frod                       | oriok           | Мол           |
| ₫                              | artm<br>ortar<br>inju   |                   | 21. Signature of Synferal Service Lic   |                                      | Me                       | morial<br>22.                       | Name a                          | nd Addres                               | s of Facility                         |                            |                            | erick,          |               |
| B                              | Depi<br>impo  |                   | 1/1/  |                                      |                          | Re                                  | stha                            | aven                                    | Funeral                               | Service                    | s, Sk                      | kot Co          | dy l          |
|                                |   |                   | 23a. Part 1. Inter the disease, or co   | mplications that caused              | the death.               | Do not enter                        | JI (                            | de of dvin                              | tin Mtn.                              | HWV. I                     | reder                      | ick, M          | D Z           |
|                                |   |                   | 23a. Part 1. Her the discase, or co<br>shoot, or heart fure. List on<br>Immediate Cause (Final              |                                      |                          |                                     |                                 |   |                                       |                            | 4.1001                     |                 | Inte          |
|                                | Physician /Medical  |                   | disease or condition resulting in death)  | _a Metastat                          |                          |                                     | ic                              | Canc                                    | er                                    |                            |                            |                 | 4 n           |
|                                | Examiner  |                   | 1   | Due to (or as a                      | conseque                 | ence of):                           |                                 |   |                                       |                            |                            |                 |               |
|                                |   | <b>1</b>          | Sequentially list conditions,   | b                                    |                          |                                     |                                 |   |                                       |                            |                            |                 |               |
| 1                              | sit 9d  | in                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a                      | r-curiseque              | nice org.                           |                                 |   |                                       |                            |                            |                 |               |
| V                              | es thet the death certificate be executed<br>igned by the ettending physicien and<br>be deteched for use as the burial transit  | Examiner          | that initiated events<br>resulting in death) Last   | C. Due to for as a                   | conconu                  | anno of):                           |                                 |   |                                       |                            |                            |                 |               |
| Box 68760,                     | cien<br>cien  |                   |   | Due to (or as a consequence of):     |                          |                                     |                                 |   |                                       |                            |                            |                 |               |
| 87                             | ate to  | S                 | •   | d                                    |                          |                                     |                                 |   |                                       |                            |                            |                 |               |
| 9                              | e as  | ₩.                | IF FEMALE:  |                                      |                          |                                     |                                 |   |                                       |                            |                            |                 |               |
| 30                             | ath co  | an/               | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of 1 Live birth |                          |                                     | ctopic p                        | regnancy                                |                                       |                            | 2                          | 3d. Date of de  |               |
|                                | he ed for   | Sic               | 1 ☐ Yes 2 No  | 4□Pregnant at t<br>9□Unknown         | time of dea              | ath 5 🗆 (                           | Other (s                        | pecify)                                 |                                       |                            | -                          | MORE            | Day           |
| P.O.                           | d by etect  | Physician/Medical | 9 Unknown   |                                      |                          |                                     |                                 |   |                                       |                            |                            |                 |               |
| Ś                              | aw requires thet the<br>ts been signed by th<br>2 should be deteche   | ρ                 | Part II. Other significant conditions   | contributing to death bu             | t not resul              | ting in the und                     | erlying                         | cause give                              | in in Part I.                         |                            |                            | se contribute t |               |
| P.C                            | w requir<br>been si<br>should   | ed d              |   |                                      |                          |                                     |                                 |   |                                       | 1                          | ]Yes 2Ĕ                    | No 3∏P          | robably       |
| S                              | e fawr<br>has be  | Completed         |   |                                      |                          |                                     |                                 |   |                                       | 24a. Wa                    | as an                      | 24b. Were a     | utopsy        |
| Ĕ                              | The ste h   | E                 |   |                                      |                          |                                     |                                 |   |                                       | per<br>1 Yes               | rformed?                   | death?          | comple<br>s 2 |
| ita                            | Tiffice<br>tor. p   | 0                 | 25. Was case referred to medical  | 7.5                                  |                          |                                     |                                 |   | 26. Place of Dea                      |                            |                            | 1   10          | 3 2           |
| >                              | Physicien:<br>this certific<br>al director.   | To B              | examiner?<br>1 ☐ Yes 2 🖾 No   | Hospital: 1 ☐ Inpatien               | nt 2□E                   | R/Outpatient                        | 3[] D                           | OA Othe                                 |                                       | lome 51⊠Re                 |                            | □Other (So.     | acifu)        |
| <u>6</u>                       | er th   | Ë                 | 27. Manner of Death   | 28a. Date of Injury                  | / 2                      | 28b. Time of                        |                                 | 28c. Injury<br>Work                     |                                       | 28d. Describe              |                            |                 | ochy)         |
| ion                            | of fun  | 읉                 | 1 Natural 5 Pending 2 Accident investigati  | (Month, Day<br>on                    | rear)                    | Injury                              | М                               |   | :?<br>∕es 2 ∐No                       |                            |                            |                 |               |
| Division of Vital Records,     | l or Attending Physicien: The I<br>after death.<br>Director: After this certificate ha<br>I in by the funeral director, page  | Certification;    | 3 Suicide 6 Could not determine   | be 200 Bloom of Injur                | ry - At hon<br>(Specify) | ne, farm, stree                     | t, factor                       | ry, office                              |                                       | 28f. Location<br>City or T | (Street and<br>own, State) | Number or F     | Rural Ro      |
| _                              | urs a<br>urs a<br>prel (  | ပ္                | 00 0 mm   | 1                                    |                          |                                     |                                 |   |                                       |                            |                            |                 |               |

1. Decedent's Name (First, Middle, Last)

328 Clear Ridge Road

5. Social Security Number

217-28**-**5582

10a. State

Usual Residence of Decedent

Anna Schwartz Valentine

10b. County

4a. Facility Name (If not institution, give street and number)

1 ☐ M 2183 F

**Physician** 

/Medical

Examiner

**Funeral** 

Director

how

Specify: White 16b. Kind of Business/Industry Agriculture Maiden Surname) er, City or Town, State, Zip Code) ige, MD 21791 20c. Location - City or Town, State Frederick, Maryland s, Skkot Cody P.A. rederick, MD 21701 Approximate Interval Between Onset and Death 4 months 23d. Date of delivery Day Year Month bacco use contribute to the cause of death? 2 🎽 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24 No dence 6 Other (Specify) now injury occurred Street and Number or Rural Route Number, vn, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D 48184 August 13, 2007

State

Registrar

(Check only one)

29b. Signature and title of certifier

Elhamy 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eskander, m7

AUG 1 5 2007

32. Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2:15 AM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Medical lente Barriew timore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs, last birthday, Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 F 91 217-01-7581 Director October 14,1915 Baltimore, Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21222 USA 12 Leeway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Crown Cork & Seal 12 years Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Bartling Martin Whittington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 35044, Baltimore, Maryland Shirley Howell Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Oak Lawn Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Important: If ite. August 18, Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland 2007 4 Donation 5 Other (Specify) 21. Signature of Fyner Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a, Part1. Enter the disease, or complications that caused the deal n. shock, or heart failure. List only one cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tai respirator /Medical Due to (or a consequence of): Examiner ROS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 ☑ No Month Vear 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has certificate sompletely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient P 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 14, 200

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

4940

30. Name and address dyperson who completed cause of death (Item 23a) (Type, Print) MI

East

Avenue Baltimore.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Anna Mae Woolfrey 10, 200 4c. County of Death 5:20a 2007 August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Stella Maris Hospice Towson Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 20, 1909 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 ☐ M 2 🔀 F Months 97 213-32-1554 PA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Beefwood Court 21221 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify: White Specify: 3€ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Salesperson Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Moore Elizabeth Huston 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Benkovic /daughter 2 Beefwood Court Baltimore MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 

Burial 2 □ Cremation 3 ☐Removal from State Meadowridge Cemetery 8/13/07 Baltimore MD 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Baltimore MD 21. Signature Fureral Ser Connelly Funeral Home of Essex 23a. Part1. Enter the dishock, or heart fau os completin ns that caused that only one cause on each line death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 📉 No 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown 24a. Was an

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

**Examiner** 

10a. State

Director

Funeral

Completed by

Be

MD

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

is marked other

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if Item 27 is marked other any injury or other traumatic event,

Baltimore, Maryland

Division or Vital Records, P.O. Box 68760

| edical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last |
|-------------------|---|
| Physician/Medical | IF FEMALE:<br>23b. Was decedent pregnan<br>in the past 12 months?<br>1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown                                |
| 0                 | Part II Other significant cor   |

Completed by

Be

<sup>2</sup>

Medical

State

autopsy 1∐ Yes 2**X** No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2X No

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 \sum Nursing Home 5 ☐ Residence 6 ▼ Other (Specify) HOSPICE 28d. Describe how injury occurred

26. Place of Death (Check only one)

TIMONIUM, MD 21093

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

27. Manner of Death

1 X Natural

2 Accident

3 ☐ Suicide

4 Homicide

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 ☐ Could not be determined

29c. License number 43725 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar DHMH 17 Rev 1/2001

|   |                   | 1 = For State Registrar   | State of Marylan  |  | artment of<br>rtificate of           |  | Mental Hy                                | /giene<br>Reg. No         | 71111                             | 7 25202  |
|---|-------------------|---|---|--|--------------------------------------|--|--|---------------------------|-----------------------------------|--|
| Physic  | ian               | 1. Decedent's Name (First, Middle, La   | •   |  |                                      |  | 2. Date of Do                            |                           |                                   | 3. Time of Death 9:52 p. M                         |
| /Medi<br>Exami  |                   | Joseph Willi<br>4a. Facility Name (If not institution, gi                               |   |  | 4b. City, Town,                      | or Location of Dea                         | Hugust                                   | - <b>9</b> , 3            | 2007<br>County of Dea             |  |
| ,   | lici              | Stella maris  |   |  |                                      | 15on                                       |  |                           | Baltime                           |  |
| Funeral<br>Director   |                   | 5. Social Security Number 6.1   | Sex 7. Age ( <i>In yrs.</i>   | last birthday)<br>Yrs.   | If Under 1 Yea<br>Months Day         |  |  | rth<br>ay, Yea <i>r</i> ) | 9. Bi                             | irthplace (State or Foreign<br>Country)<br>G(Y/Gnd |
| yland<br>now<br>at  |                   | Usual Residence of Decedent  10a. State 10b. County                                     | 10c. Cit  | y, Town or Lo  | cation                               |  |  |                           |                                   | 10d. Inside City Limits                            |
| ne Mar<br>8a-f sl   | Director          |   | timore t  | ) KCSV   | ille                                 |  |  |                           |                                   | 1 □Yes 2 No  |
| with the age of 2 the no  | Dire              | 10e. Street and Number  | 401 70  |  | 10f. Zip Code                        |  |  |                           | tizen of What C                   | Country?   |
| death<br>ms 23  | Funeral           | 2 VVInd Blown  11. Marital Status   | 12. Was Decedent Ever in U  | .S. 13.  | Was Decedent of                      | Hispanic Origin? (                         | Specify Yes or No                        |                           | 5. A<br>14. Race - Am             |  |
| ING Z IZ I 35-UU30<br>be filed within 72 hours after death with the Maryland<br>ital Hygiene.<br>dother than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notifited at  | by Fu             | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced                                  | Armed Forces?  1  |  | ir Yes, specify Cu<br>1 □ Yes 2 💢 No | iban, Mexican, Puè<br>o <i>Specify:</i>    | по Hican, etc.)                          |                           | Black, Wh                         | ,  |
| 5-UU36 72 hours at reatural", or dical Exam   | ted b             | 15. Decedent's E  | ducation  | 16a. Dece  | dent's Usual Occ                     | upation                                    |  | 16b. K                    | ind of Business                   | /ac/C<br>s/Industry                                |
| ZIS   | Completed         | (Specify only highest gr  | ade completed)  College (1-4or 5+)  | (Give  | DO NOT use retii                     | *  | orking                                   |                           |                                   |  |
| A B B P   | S                 | 17. Father's Name (First, Middle, Las   | *)  |  | Laborer                              |  | ıme (First, Middle                       | Bal                       | timere                            | City   |
|   | To Be             | Herman Braxton  | ,   |  |                                      |  |  |                           |                                   |  |
| re, INIALYIA s 1 and 2 should f Health and Men ttem 27 Is marke other traumatic   | -                 | 19a. Informant's Name/Relationship  | (Type. Print)   | 19b. Mailir  | _                                    | Mary in a set and Number or F              |  |                           |                                   |  |
| C = W F   |                   | Cleanor E. Hairs  |   | 632  | Glen                                 | Albor Co                                   | ourt Sei                                 | ien v                     | alleys                            | ,PA 17360  |
| 9 = 5<br>0 = 5  |                   | 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □                                 | Removal from State  | emetery, crei  | natory or other pr                   | ace)                                       |  | ł                         |                                   |  |
| DallIMOTE, permit. Pages 1 a Department of Hee Important: If item any Injury or othe  |                   | 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice                       |   | 111150n  | 2. Name and Add                      | ress of Facility V                         | 11.07<br>Jugha C. (                      | Sie                       | ne Hung                           | ills, mD<br>al Service                             |
| Deart<br>permit.<br>Depart<br>Import<br>any Inj   |                   | Warden C. M   | Alone   |  |                                      | seity Prid                                 |  |                           |                                   |  |
|   |                   | 23a. Part1. En er the disease, or con<br>shock, or heart failure. List only             | pplications that caused the deat<br>one cause on each line.                             |  |                                      |  |  |                           |                                   | Approximate<br>Interval Between<br>Onset and Death |
| Physician<br>/Medical   |                   | Immediate Cause (Final disease or condition resulting in death)                         | a. HUMAN IMMUNO   |  | LENCY VI                             | RUS  |  |                           |                                   | Onset and Death                                    |
| Examiner  | ı                 |   | Due to (or as a conseq  | uence of):   |                                      |  |  |                           |                                   |  |
| 7 D #   | iner              | Sequentially list conditions, if any leading to immufact cause. Enter Underlying        | b. Due to or as a conseq  | lience of  |                                      |  |  |                           |                                   |  |
| be executed ician and burial-transit  | Examine           | Cause (Disease or injury that initiated events resulting in death) Last                 | cDue to (or as a conseq.  | uence of):   |                                      |  |  |                           |                                   |  |
| ficate be executed physician and streets the burial-transit   |                   |   | . d   | acrice or,   |                                      |  |  |                           |                                   |  |
| tificate<br>ng phy<br>as the  | ledic             |   | 0   |  |                                      |  |  |                           |                                   |  |
| ath cer   | an/In             | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?                      | 23c. If yes, outcome pf pregna<br>1 □ Live birth 2 □ Feta                               | Ideath 3   | ]Ectopic pregnan                     | су   |  | 70                        | 23d. Date of de                   |  |
| ysician: The law requires that the death certificate is certificate has been signed by the attending physidirector, page 2 should be detached for use as the  | Physician/Medical | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4□Pregnant at time of d<br>9□Unknown  |  | Other (specify)                      |  |  |                           | Month                             | Day Year   |
| that the the part of the part of the the character of the character | y Ph              | Part II. Other significant conditions   | contributing to death but not res   | ulting in the u  | nderlying cause g                    | iven in Part I.                            | 23e. Did                                 | tobacco u                 | use contribute t                  | to the cause of death?                             |
| equires<br>en sign  | ed by             |   |   |  |                                      |  | 10                                       | Yes 2                     | □No 3□F                           | Probably 4 Vunknown                                |
| The law requires the has been signed age 2 should be considered.  | Completed         |   |   |  |                                      |  | 24a. Was                                 |                           | 24b. Were a                       | autopsy findings available completion of cause of  |
| i: The  |                   |   |   |  |                                      |  | perfe<br>1□ Yes                          | ormed?<br>2 No            | death?                            |  |
| Physician: Tribis certificat  | Be C              | 25. Was case referred to medical examiner?  1  Yes 2  No                                | Hospital:   | ED/Outration   |                                      | 41   | ath (Check only                          |                           |                                   |  |
| g Phy<br>er this  | n: To             | 27. Manner of Death   | 28a. Date of Injury (Month, Day Year)   | 28b. Time of   | , oll box                            | 4 Li Nursing                               | Home 5 L Resi<br>28d. Describe           |                           |                                   | ecify) HOSPICE                                     |
| r Attending<br>ter death.<br>irector: Afte  | atio              | 1 Natural 5 Pending 2 Accident investigatio   | n   | Injury   |                                      | ork?<br>]Yes 2 □ No                        |  |                           |                                   |  |
| l or Att<br>after de<br>Direct  | Certification:    | 3 Suicide 6 Could not b<br>4 Homicide determined  |   | ome, farm, str   | eet, factory, office                 | 9  | 28f. Location (<br>City or To            | Street an<br>wn, State    | nd Number or F<br>e)              | Rural Route Number,                                |
| To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral directors.  | Medical Co        | 29a. Certifier 157 Certifying Pl<br>(Check only one) 2 Medical Example (Check only one) | nysician: To the best of my kno<br>miner: On the basis of examina<br>and manner stated. | wledge, death<br>tion and/or in  | n occurred at the vestigation, in my | time, date and place<br>opinion, death occ | ee, and due to the<br>curred at the time | cause(s)                  | ) and manner a<br>d place, and du | as stated.<br>ue to the cause(s)                   |
| To the within To the comple   | Me                | 29b. Signature and title of certifier   | and manner stated.  |  | 29c. Licer                           | nse number                                 |  | 29d. Da                   | te signed (Mon                    | oth, Day, Year)                                    |
|   |                   | 1   |   |  |                                      | 143721                                     |  |                           | 8/10/0                            | 7  |
| 1   |                   | 30. Name and address of person who  |   |  |                                      |  |  |                           | 1                                 |  |
| Sta   | ate               | DR. TARIQ MAHMOO  |   | Y VALL   | EY RD.                               | TIMONIUM                                   | , MD 210                                 | 93                        |                                   |  |
| Registr   |                   | AUG 1 5 20  | Registrar's Signa   | The state of the s | Pos                                  |  |  |                           |                                   |  |

JOSEPH WILLIAMS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per fh 9870 8-15-07 vt

State of Maryland / Department of Health and Mental Hygiene amend item 7 per fh 8776 8 16 97 avt Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Linda William /Medical 6, 2001 4c. County of Death 2007 1.15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 1301-5ero Hospita IRS Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 212-60-452 Yrs. Director 555 Maryland Aug 9, 1951 Usual Residence of Decedent Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director **Baltimore** N/A Maryland with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or adical Examiner must be r U.S.A. 1639 Booker Court 21217 by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. Black 3 ☐ Widowed 4 ☐ Divorced Be Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home **Nursing Assistant** 12 uith and Mental Hygie 27 Is marked other I r traumatic event, th other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances B. Jones Floyd C. Jones Sr. ဂ္ 19a. Informant's Name/Relationship (Type. Print)
Lisa
Linda Jones Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau 1639 Booker Court Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 DRemoval from State 08/14/07 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify)  ${ t Metro}$ Crematory re of Funeral Servi 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the dear shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate use (Final disease or ondition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, the Ling to Interest as cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) 9 Unknown is been signed by t 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No cate has page 2 s autopsy perform certificate 2 1 No Yes Attending Physiclan; funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A
filled in by the fu death. 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Ь the Hospital thin 24 hours at within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death

31. Date filed (Many)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Jilkinson do 2007 nge /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner 22 S Greene N/A of Manylord oltimere If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5 Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 👿 F Maryland Jun 26, 1979 28 Director 216-06-3546 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or Items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No **Baltimore** Director N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21229 590 Lucia Avenue Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Black Specify. ð 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 filed within 7 Hygiene. **Essex Community College** College (1-4or 5+) Elementary/Secondary (0-12) Advisor 12 should be filed w and Mental Hygier ' is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernestine Harris Joseph H. Wilkinson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) iit. Pages 1 and 2 sartment of Health ar sortant: If item 27 is y Injury or other tre 2150 Lorraine Avenue Baltimore, Maryland 21207 Joseph H. Wilkinson Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Removal from State Department o Important: If any Injury or Windsor Mill, Md. 08/15/07 King Memorial Park 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ture of Fune Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part : Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in ... Approximate Interval Between Onset and Death Immediate Cause (Final Physician DOXIG disease or condition resulting in death) /Medical consequence of) Due to (or as **Examiner** tobalic Secuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a consequence of Examiner be executed CERTIFY and burial-trar Due to (or as a consequence of) attending physician for use as the burial Box 68760, Physician/Medical Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 □ No P.O. the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ş 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ... autopsy performed? Yes 2 No certificate 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 1 npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After Year) Injury 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes Vehicle Collision 130 07 9 IOL after death 6 ☐ Could not be PI ce of injuly - At hom building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide At home, farm, street, factory, office 28f. filled in by 4 ☐ Homicide -95 at Cation roadway 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 hours a Medical 29a. Certifier within 24 hor To the Fune completely f the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier riccan

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

Greane

32. Registrar's Signature

Bo Himen

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

26205

| 100         | Dhanisi   |                | 1. Decedent's Name (First, Middle, Last)  |                               |  |                           |                         |                                     |   | ath 3. Time of Death                  |                               |                                       |  |
|-------------|---|----------------|---|-------------------------------|--|---------------------------|-------------------------|-------------------------------------|---|---------------------------------------|-------------------------------|---------------------------------------|--|
|             | Physici<br>/Medio   |                | ALFRED  |                               |  |                           |                         | WOODS                               |   | AUGUST                                | Day<br><b>9</b>               | 2007                                  | 7:58 P M   |
| -           | Examir  |                | 4a. Facility Name (If not ins   | titution, give s              |  |                           |                         |                                     | or Location of Death                      | )                                     | 4c. C                         | County of Death                       |  |
|             |   | 91             | 4730 ATRIUN   |                               |  |                           |                         |                                     | MILLS                                     |                                       |                               | BALTIM                                |  |
| Ŀ           | Funeral<br>Director   |                | 5. Social Security Number 219-03-4518   | 6. Sex                        | 7. Ag<br>(M 2□F  | e (In yrs. last bir<br>90 |                         | Months Days                         | If Under 24 Hrs.<br>Hours Min.            | 8. Date of Bir (Month, Date 09/12/    | 1916                          | 9. Birthp<br>Cour                     | lace (State or Foreign<br>try) MI                  |
|             | pui v   |                | Usual Residence of Deceder<br>10a. State 10b. C                                   |                               |  | 10c. City, Tow            | n or Loca               | ation                               |   |                                       |                               | 1                                     | 0d. Inside City Limits                             |
|             | laryla<br>sho   | 5              |   | •                             | 40DE   |                           |                         |                                     |   |                                       |                               | '                                     | 1 ☐ Yes 2 X No                                     |
|             | the N<br>28a-f<br>notifie   | Director       | MD<br>10e. Street and Number  | BALTIM                        | TUKE   | UWJ                       | 11165                   | MILLS<br>10f. Zip Code              |   |                                       | 10g. Citizen of What Country? |                                       |  |
|             | 3a or   | i              | 3411 RIPPLE   | ROAD                          |  |                           |                         | Tot. Zip Code                       | 21207                                     |                                       | rog. Onize                    | US <i>F</i>                           | ·  |
|             | ms 2  | Funeral        | 11. Marital Status  |                               | 12. Was Decedent I<br>Armed Forces?                      | Ever in U.S.              | 13. W                   | as Decedent of I                    | Hispanic Origin? (Span, Mexican, Puerl    | pecify Yes or No                      | )- 14                         | 4. Race - Americ                      | an Indian,   |
| 5-0036      | be filed within 72 hours after death with the Maryland ttal Hygiene.  Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by             | 1 □ Never Married 22<br>3 □ Widowed 4 □ Div                                       | Married                       | 1 M Yes 2 ☐ N<br>If Yes, Give<br>Year or Dates:          | ∿ WWII<br>NAVY            |                         | Yes, specify Cub<br>☐ Yes 2. No     | Specify:                                  | o Rican, etc.)                        |                               | Black, White,<br>Specify: WH]         |  |
| 2           | 72 hc<br>natur<br>dical   | eted           | 15. De<br>(Specify only   | cedent's Educ                 | cation<br>e completed)                                   | 16a.                      | (Give ki                | nt's Usual Occup                    | during most of wor.                       | kina                                  |                               | d of Business/Inc                     |  |
| 2121        | within<br>iene.<br>than "   | Completed      | Elementary/Secondary (0   |                               | College (1-4or 5   | i+)                       | life. Do                | O NOT use retire                    | d) -                                      |                                       |                               | OCIAL SE<br>MINISTRA                  |  |
|             | e filed<br>al Hygi<br>other<br>/ent, t  | Be             | 17. Father's Name (First, N   | liddle, Last)                 |  |                           |                         |                                     | 18. Mother's Nam                          | ne (First, Middle                     |                               |                                       |  |
| <u>a</u>    | should be<br>ind Mental<br>marked c   | To E           | VICTOR  |                               |  |                           | W001                    | )                                   | JENNIE                                    |                                       |                               | TU                                    | MIN  |
| Maryland    | d 2<br>th a<br>tra  |                | 19a. Informant's Name/Rel   |                               |  | 1                         |                         |                                     | ROAD, BAI                                 |                                       |                               | Town, State, Zip<br>21207             | Code)  |
| altimore,   | es 1 an<br>of Heal<br>fitem 2<br>rother   | 7.5            | 20a. Method of Disposition<br>1 X Burial 2 ☐ Crem                                 | ation 2 D                     | amoual from State  | 20b. Place of             | f Disposi               | tion (Name of                       | ре)                                       | Date                                  | 20c. Loca                     | ation - City or To                    | wn, State  |
| Ĕ           | Page<br>ment c<br>ant: If   | 7.5            | 4 □Donation 5 □Ot   | her (Specify)                 | C State  | BALCE                     | METI                    | ERY                                 | 08/12                                     | 2/2007                                | REIST                         | TERSTOWN                              | l, MD  |
| gall        | permit. Pag<br>Department<br>Important:<br>any Injury once.   |                | 31. Sign sture of huneral S   | e Licens                      |  |                           |                         | Name and Addre                      |   |                                       |                               | & BROS.,                              |  |
|             | PD = 8 0  | 10             | Jatus   | 11.                           | James  | ha da ath Da              |                         |                                     | TERSTOWN                                  |                                       |                               | SVILLE,                               |  |
|             |   |                | 23a. Part1. Enter the diseashock, or heart failure<br>Immediate Cause (Final      | . List only on                | ne cause on each lir                                     | ne.                       | not enter               | Ne mode of dyl                      | ng, such as cardiac                       | or respiratory a                      | rrest,                        | 23                                    | Approximate<br>Interval Between<br>Onset and Death |
| =           | Physician<br>/Medical   |                | disease or condition resulting in death)  | a                             | 1. 1412h   | a consequence             | of).                    | 16                                  | easo                                      |                                       |                               |                                       |  |
|             | Examiner  |                |   | Ь                             |  | a concoquonos             | 01/.                    |                                     |   |                                       |                               |                                       |  |
|             | P ##  | iner           | Sequentially list conditions if any, leading to immediate cause. Enter Underlying | , <b>J</b> °                  |  | a consequence             | of):                    |                                     |   |                                       |                               |                                       |  |
|             | be executed<br>ician and<br>burial-transit  | Examiner       | that initiated events<br>resulting in death) Last                                 | c                             | Due to (or no  | a consequence             | of):                    |                                     |   |                                       |                               |                                       |  |
| 08/PU,      | eath certificate be executed attending physician and for use as the burial-transit  |                |   |                               | Duc to (or as  | a consequence             | 01).                    |                                     |   |                                       |                               |                                       |  |
| 000         | tificati<br>ig phy<br>as the  | cian/Medical   | A-12  | -0                            | · Income   |                           |                         |                                     |   |                                       |                               |                                       |  |
| Z<br>Q<br>Q | tth cer<br>tendin<br>r use  | an/N           | IF FEMALE:<br>23b. Was decedent pregna<br>in the past 12 months                   | uit                           | 3c. If yes, outcome<br>1 ☐ Live birth                    | 2 Fetal death             | 3 □E                    | ctopic pregnanc                     | v   |                                       | 23                            | Bd. Date of delive                    | •  |
| 5           | requires that the death certificate een signed by the attending physi hould be detached for use as the  | Physici        | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | r                             | 4□Pregnant at<br>9□Unknown                               | time of death             | 5 🗆 (                   | Other (specify) _                   | _   |                                       |                               | Month                                 | Day Year   |
| 7           | s that<br>ned by<br>deta  | by Ph          | Part II. Other significant co   | onditions con                 | ntributing to death bu                                   | ut not resulting in       | the und                 | erlying cause giv                   | ren in Part I.                            | 23e. Did t                            | obacco use                    | e contribute to the                   | e cause of death?                                  |
| ecoras,     | w requires that the d<br>been signed by the<br>should be detached   | ed b           |   |                               |  |                           |                         |                                     |   | 1 🗆                                   | Yes 2                         | No 3☐ Prob                            | ably 4 □Unknown                                    |
| ပ္သ         | > - S   | Completed      |   |                               |  |                           |                         |                                     |   | 24a. Was                              |                               | 24b. Were auto                        | psy findings available                             |
| <u> </u>    | Physician: The lav<br>this certificate has<br>ral director, page 2.   | Com            |   |                               |  |                           |                         |                                     |   | perfo<br>1∐ Yes                       | ormed?<br>2 No                | death?                                | 2□ No  |
| N I I I     | cian;<br>ertific<br>ector,  | Be (           | 25. Was case referred to mexaminer?   |                               |  |                           |                         |                                     | 26. Place of Dea                          | th (Check only o                      | one)                          |                                       |  |
|             | g .g .₹   | 2              | 1 Yes 2 No<br>27. Manner o Death  |                               | lospital:<br>1 ☐ Inpatie                                 |                           | tpatient<br>Time of     | 3 DOA Oth                           | 4 LI Nursing H                            |                                       |                               | Other (Specify                        | assisted<br>Living                                 |
|             | ding<br>h.<br>After<br>funer  | ţio            | 1 Natural 5 □ F   | Pending<br>nvestigation       | (Month, Day  |                           | njury                   | 28c. Inju<br>Wo<br>M 1              | ryat<br>rk?<br>∣Yes 2∐No                  | 28d. Describe                         | now injury                    | occurred                              |  |
| VISION      | Atten<br>r deat<br>ector;<br>by the   | ifica          | 3 Suicide 6 □ C   | Could not be letermined       | 28e. Place of inju                                       | ury - At home, fa         | rm, stree               |                                     | 100 20.10                                 | 28f. Location (                       | Street and                    | Number or Rura                        | I Route Number,                                    |
| 5           | tal or<br>rs afte<br>ral Dir  | Certification: | 4Hornicide  |                               | building, etc  | с. (Specify)              |                         |                                     |   | City or To                            | wn, State)                    |                                       |  |
|             | To the Hospital or Attending Pt within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral                                       | Medical        | 29a. Certifier 1 Ce<br>(Check only one) 1 Me                                      | rtifying Phys<br>dical Examir | sician: To the best oner: On the basis of and manner sta | examination an            | e, death o<br>d/or inve | occurred at the tiestigation, in my | me, date and place<br>opinion, death occu | , and due to the<br>rred at the time, | cause(s) a<br>date and p      | and manner as si<br>place, and due to | ated. the cause(s)                                 |
|             | To th<br>Withir<br>COMP   | Me             | 29b. Signature and title of o   | ertifier                      | 1  | ·                         |                         | 29c. Licens                         | se number                                 |                                       | 29d. Date                     | signed (Month,                        | Day, Year)   |
|             | 1   |                | 1 (de   | 19                            | MA)  |                           |                         | DI                                  | 5872                                      |                                       | Au                            | usx/                                  | 0,2007   |
| 1           | 54  | ļ              | 30. Name and address of p   | erson who co                  | mpleted cause of de                                      | eath (Item 23a) (         | Type, Pi                | int)                                | ( - 1                                     |                                       |                               | /                                     |  |
|             | 9   |                | 31. Date filed (Month, Day,   | Ka /                          | 13 MD  | 25 Mo<br>ar's Signature   | an                      | s mee                               | f 211                                     | 56                                    |                               |                                       |  |
|             | Sta   |                | 3 L Date filed Ovionin, Dav.  | rear)                         | 32. Benistra   | ars Signature             |                         |                                     |   |                                       |                               |                                       |  |

DHMH 17 Rev 1/2001

State

Registrar

AUG 1 5 2007

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: To the Funeral Director; After this certific completely filled in by the funeral director, within 24 hours a To the Funeral I

State Registrar

31. Date filed (Month, Day, Year)

29a. Certifier

29b. Signature

(Check only one)

29d. Date signed (Month, Day, Year)

1 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

07-06168

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| anet famis   | State of Maryland / Department of Health and Mental Hygi  | 211                                 | 77 2620   |
|--|---|-------------------------------------|---|
| Physician/   | Registrar  1. Decedent's Name (First, Middle,Last)  2.  | Reg. NoDate of Death                | 3. Time of Death                                  |
| Medical Examine  | mer JANET YARNIS A  | Month Day Year<br>August 11, 2007   | 0340 hrs  |
|  | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death  Sinai Hospital  Baltimore  | 4c. County of Deat                  |   |
|  | -   | Date of Birth(MM/DD/YYYY) 9. Bi     | N/A   |
| Funeral<br>Director  | Months Days House Min   | Forei                               |   |
| w any  | 10a. State 10b. County 10c. City, Town or Location  |                                     | 10d. Inside City Limits                           |
| ryland<br>a-f show<br>at once.   | BALTIMORE   |                                     | 1 X Yes 2 No                                      |
| th the Maryland 23a or 28a-f sho notified at once.   | 10e. Street and Number 10f. Zip Code 2259 ROGENE DRIVE 21209  | 10g. Citizen of What Cou            | intry?  |
| ith the 23a of 10til   |   | U.S.A.                              | rican Indian, Black,                              |
| eath w items items ust be  | if Yes, specify Cuban, Mexican, Puerto Ric  |                                     | moan maran, black,                                |
| iffer d  |   | Specify: WH                         | ITE   |
| ours a satura kamij  | 45 D 1 1 5 D 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | done 16b. Kind of Business          |   |
| 36<br>n 72 t<br>nan "r<br>isal E   | Elementary/Secondary (0-12) Collage (1-4 or 5+)   |                                     |   |
| 5-00% Illed within Hygiene I other the Med   | 15. Decedent's Education (Specify only highest grade completed)    Specify only highest grade completed   15. Decedent's Usual Dccupation (Giva kind of work of during most of working life. DO NOT use retired)   12   | rst, Middle, Maiden Surname)        | lE .  |
|  | 8 SOL LIPKIN MARGARET   |                                     | INABLE  |
| e, MD 2121: I and 2 should be fil Health and Mental I item 27 is marked r fraumatic event,   | 2 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rura   | al Route Number, City or Town, Stat | e, Zip Code)                                      |
| e, MD I and 2 sho Health and item 27 is fraumati   | GLENN YARNIS / SON 9 MANCHESTER COURT - MO  |                                     | J <b>97960</b>                                    |
| 5 ± ± ± = 1  | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery,  1 X Burial 2 Cremation 3 Removal from State MARYLAND VETERANS  08/14/   | 20c. Location - City of OWINGS MI   |   |
| Baltimore,<br>bermit. Pages I ar<br>Department of Her<br>Important: If ite<br>njury or other tr  | 4 Donation 5 Other Specify:   |                                     |   |
| Baltimo<br>permit. Page<br>Department<br>Important:<br>injury or otd   |   | OL LEVINSON & BE                    |   |
| Physician  | 23a. Part / Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or refailure. List only one dause on each line.  |                                     | Approximate Interval                              |
| /Medical<br>Examiner   |   | Between Onset and<br>Death          |   |
| Examiner   | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequenca of):   |                                     |   |
| 4  | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):   |                                     |   |
| <b></b>  | cause. Enter Underlying Cause   |                                     |   |
| Exa  | events resulting in death) Last  Due to (or as a consequence of):   |                                     |   |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit pedical Certification: To Be Completed by Physician/Medical Exited in the funeral certification of the funeral certification. | UNPENDED AMENDED 4a per me, 19b per th g8/0 8-15  | -07 vt                              |   |
| 760, cate be physici he buri   | IF FEMALE: 23c. If yes, outcome of pregnancy  | 23d. Date of delive                 | ry  |
| Sox 687 (death certificate attending place as the vertical for use as the vertician/A  | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy   | Month                               | Day Year  |
| Box 687 e death certific the attending ped for use as the  | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  Contributing to death but not resulting in the underlying cause given in Part I.  | 1 4000                              |   |
| that the d   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  | 23e. Did tobacco use contribute t   |   |
| s, P.C<br>ires that<br>signed<br>the deta  | pa pa   |                                     | obably 4 🗹 Unknown                                |
| ords, I w requires is been sig should be   | Completed   | autopsy prior to                    | autopsy findings available completion of cause of |
| Vital Recc<br>vysician: The lav<br>finis certificate ha<br>director, page 2  |   | performed? death?                   | res 2 No  |
| tal Rection: The certificate ector, page   | 25. Was case referred to medical 26.Place of Death (Check only  |                                     |   |
| Physic rathis ral dir  | 1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing F  | d. Describe how injury occurred     | er:   |
| Division of Vital Records, P.O. rial or attending Physician: The law requires that the safe death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director. To Re Completed by Partification: To Re Completed by Partification:   | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No  28b. Time of Injury 28c. Injury at Work? 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work? 28b. Time of Injury 28c. Injury at Work?   | d. Describe now injury decarred     |   |
| iSiC<br>Atter<br>er dear<br>rector<br>by th  | 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28  | f. Location (Street and Number or F | Rural Route Number, City                          |
| Div  | Suicide 6 Could not be determined (Specify)   | or Town, State)                     |   |
| Hosp 24 ho Fune etely fi   |   |                                     |   |
| Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the   | Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and du one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and du one)  2 Signature and title of certifier  29c. License number   |                                     |   |
| ≥  | $\bigcirc$  | 29d. Date signed (M                 |   |
|  | tatillronic Toller is O.C.M.E.  | August 12, 200                      | 1   |
| S  | 30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica=Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore,  | MD 21201                            |   |
| State  | ate 31. Date filed (Month) Pro, Year) 2007 32. Segistrar's Signature  |                                     |   |
| Registra   | BUG I S /III/ Pro-c Per Pro-c |                                     | ł   |

Ammended Boxs 10e, 10c, 10f per fd ammended 26-5, 29d per phys. CCHD WSH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

|            |  |                 | For<br>State<br>Registrar  | State of Ma  | aryland            |                                       | artment of a<br>rtificate of                            |                                       | ,                                    | giene<br>Reg. No.  | 0.7  | 25203  |
|------------|--|-----------------|--|--|--------------------|---------------------------------------|---|---------------------------------------|--------------------------------------|--|--|--|
|            | Physicia   | an              | 1. Decedent's Name (First, Middle  |  | Tν                 | -                                     |   |                                       | 2. Date of De<br>Month<br>July       | ath<br>Day<br>29   | 2007                                       | 3. Time of Death                                       |
|            | /Medic<br>Examin   | 6 D             | William Berna 4a. Facility Name (If not institution  |  | υĽ                 |                                       | 4b. City, Town,   | or Location of Deat                   |                                      |  | ounty of Death                             |  |
|            |  |                 | 465 East Green   |  | . (1 1             | 4 1 - 4 1 - 4 - 1 1                   |   | inster                                | O Date of Bird                       | Ne   | Carro                                      |  |
|            | Funeral<br>Director  |                 | 5. Social Security Number 215-34-5876 Usual Residence of Decedent  | 6. Sex 7. Age 11   | 7 (in yrs. i       | ast birthday) Yrs.                    | Months Days   |                                       |                                      | y, Year)   | 9. Birti                                   | nplace (State or Foreign<br>intry)<br>MD               |
|            | Maryland<br>-f show<br>ied at  | tor             | 10a. State 10b. County   | roll   | 10c. City          | , Town or Lo                          | cation<br>cinster                                       | Tane                                  | ytown                                |  |  | 10d. Inside City Limits 1X Yes 2 □ No                  |
|            | with the<br>3a or 28a<br>st be notii   | al Director     | 1118 Grand Dri<br>465 East Cree  | ve<br><del>n Street</del>  |                    |                                       | 10f. Zip Code   | 1 <del>157 2</del>                    | 1787                                 | 10g. Citizen of What Country? USA                              |  |  |
| 020        | ges 1 and 2 should be filed within 72 hours after death with the Maryland<br>to f Health and Mental Hygiene.  To fleetine 27 is marked other than "natural" or items 23a or 28a-f show<br>or other traumatic event, the Medical Examiner must be notified at   | by Funeral      | 11. Marital Status  1 Never Married  Marri 3 Widowed 4 Divorced  | 12. Was Decedent E<br>Armed Forces?<br>ed 1 Tyes 2 1<br>If Yes, Give<br>Year or Dates: |                    |                                       | Was Decedent of<br>If Yes, specify Cu<br>1 ☐ Yes 2⁄2 No | Hispanic Origin? (Sban, Mexican, Puer | Specify Yes or No<br>to Rican, etc.) | 14. Race - American Indian, Black, White, etc.  Specify: White |  |  |
| 0-017      | vithin 72 ho<br>ne.<br>han "natur<br>e Medical I   | Completed       | 15. Decedent<br>(Specify only highes<br>Elementary/Secondary (0-12)<br>12  | 's Education<br>it grade completed)  College (1-4or 5                                  | +)                 | 16a. Dece<br>(Give<br>life.           |   | e during most of wo<br>red)           | orking                               |  | d of Business/I                            |  |
| 7          | filed w<br>Hygier<br>ther th   |                 | 17. Father's Name (First, Middle,  | Last)  |                    |                                       | Laborer   | T-                                    | me (First, Middle,                   |  | mey Suj<br>Gurname)                        | obtă   |
| 0          | should be to the marked or the | To Be           | William Bernar   |  | Sr                 |                                       |   |                                       | ra Shoem                             |  | •  |  |
| _          | 1 and 2 should be filed withi<br>Health and Mental Hygiene.<br>em 27 Is marked other than<br>other traumatic event, the M  |                 | 19a. Informant's Name/Relationship (Type. Print)  Lisa Beaumont/daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 465 E. Green Street Westminster, MD 2   |  |                    |                                       |   |                                       |                                      |  |  |  |
| פ          | Pages 1 a<br>nent of Hea<br>int; If item<br>iry or othe  |                 | 20a. Method of Disposition 1 ☐ Burial 2X Cremation 4 ☐ Donation 5 ☐ Other (S)  |  |                    |                                       | osition (Name of<br>matory or other pl<br>Crematic      |                                       | 172007                               |  | ation - City or ostead,                    | ŕ  |
| Dall       | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.   |                 | 21. Signature of Funeral Service Licenses Pritts Funeral Home and Chapel, P. 412 Washington Road Westminster,  |  |                    |                                       |   |                                       |                                      |  | , P.A.<br>er, MD                           | 21157  |
|            | Physician<br>/Medical<br>Examiner  |                 | 23a. Part1. Enter the disease, or<br>shock, or heart failure. List<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | complications that caused only one cause on each line.  a                              | SCI                | n. Do not ent                         | ter the mode of dy                                      |                                       |                                      |  |  | Approximate Interval Between Onset and Death MOPTHS    |
|            | ficate be executed<br>physician and<br>is the burial-transit   | al Examiner     | Sequentially list conditions, if any, leading to immediate cause. Find the distribution of the cause (Disease or Injury that initiated events resulting in death) Last   | b  |                    |                                       |   |                                       |                                      |  |  |  |
| O. BOX 007 |  | ysician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown                        | 2 Feta             | death 3[                              | ⊒Ectopic pregnan<br>⊒ Other <i>(sp</i> ec <i>ify)</i>   | icy                                   |                                      | 23   | 3d. Date of deli<br>Month                  | very<br>Day Year                                       |
| US, L      | quires that<br>r signed by<br>lld be deta  | d by Phys       | Part II. Other significant condition   | ons contributing to death bu   | ut not resu        | ulting in the u                       | inderlying cause g                                      | given in Part I.                      | 23e. Did 1                           |  |  | the cause of death?                                    |
| חבבת וו    | : The lay rec  | Completed       |  |  |                    |                                       |   |                                       | 24a. Was<br>auto<br>perfo<br>1∐ Yes  | psy<br>ormed?  | 24b. Were au<br>prior to death?<br>1 ☐ Yes | topsy findings available completion of cause of 2 ☐ No |
|            | To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours after death within 24 hours after death.  To the Funeral Director: After this certific te has leen signed by the attending completely filled in by the funeral director, age 2 should be detached for use a  | tion: To Be     | 25. Was case referred to medical examiner?  1 ☐ Yes ≥ No  27. Manner of Death  1 → Natural 5 ☐ Pendin 2 ☐ Accident investig  | 28a. Date of Inju<br>(Month, Da)   | ry                 | ER/Outpatier<br>28b. Time o<br>Injury | of 28c. Inj   | ther: 4 \( \text{Nursing} \)          | Home 28d. Describe                   | idence 6   | Other (Specoccurred                        | Daughter's<br>Residence                                |
|            | al or Atten<br>after deat<br>Directors<br>d in by the  | Certification:  | 3 Suicide 4 Homicide  6 Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Ru City or Town, State)   |  |                    |                                       |   |                                       |                                      |  |  |  |
|            | ne Hospitt<br>n 24 hours<br>ne Funera<br>pletely fille   | edical C        | (Check only 2 Medical one)   | g Physician: To the best of<br>Examiner: On the basis of<br>and manner sta             | f examina<br>ated. | tion and/or in                        | nvestigation, in my                                     | y opinion, death occ                  | curred at the time                   | , date and   | place, and due                             | to the cause(s)  |
|            |  | Me              | 29b. Signature and title of certified with a certified wi | in thesen,   | M.J                | ),                                    | 29c. Lice   | o 14 317                              |                                      | 29d. Date  | signed (Monti                              | h, Pay Year)<br>2007<br><b>2508</b>                    |
|            | WJL<br>3   | 7. 0            | 30. Name and address of person WILL'AM R.  | who completed cause of do  | eath (Item         | 23a) (Type,                           | Print) KIN  | 65 DRIV                               | E, TANE                              | Y704   | یم راد                                     | 21787  |

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 1 2007

32. Refetrar's Signature

| Please Type or Print in                  | n Black Indelible Ink. Ensure                               | All Copies Are Legible. | 25209            |  |  |  |  |  |  |  |
|--|---|-------------------------|------------------|--|--|--|--|--|--|--|
| State of Maryl                           | State of Maryland / Department of Health and Mental Hygiene |                         |                  |  |  |  |  |  |  |  |
| 1 - State Of Mary II                     | Certificate of Death  | Reg. No.                |                  |  |  |  |  |  |  |  |
| 1. Decedent's Name (First, Middle, Last) |   | 2. Date of Death        | 3. Time of Death |  |  |  |  |  |  |  |

|           | Physicia   | an |
|-----------|--|----|
|           | /Medic   | al |
| <b>V</b>  | Examin   | er |
| 1         | Examin   | ٠. |
|           | and the same of th |    |
|           | Funeral  |    |
|           | Director   |    |
| 10th 3633 | to object the Comme  |    |

| 95                | 49  | ш                    | 1. Decedent's Name (Firs                               | st, Middle, Last)                     |  |                     |                       |  |                                     |                   |                    | 2. Date of De<br>Month         | ath<br>Day                  | Year                           | 3. Time of Death                               |
|-------------------|---|----------------------|--|---------------------------------------|--|---------------------|-----------------------|--|-------------------------------------|-------------------|--------------------|--------------------------------|-----------------------------|--------------------------------|--|
|                   | Physici<br>/Medic   |                      | CIVE DICUIDE AIDDINCE                                  |                                       |  |                     |                       |  |                                     |                   |                    | JULY                           |                             |                                |  |
|                   | Examin  |                      | 4a. Facility Name (If not in                           | nstitution, give s                    | treet and number                         | )                   |                       | 4b. City,                              | Town, o                             | r Location        | n of Death         |                                | 4c. Cou                     | unty of Death                  |  |
|                   |   |                      | MORAN MANO   |                                       |  |                     |                       |  |                                     | RNPOI             |                    |                                |                             | LLEGAN                         |  |
|                   | Funeral   |                      | 5. Social Security Numbe                               |                                       | 7. A                                     |                     | ast birthday)<br>Yrs. | If Under<br>Months                     | Days                                | Hours             | er 24 Hrs.<br>Min. | 8. Date of Birl<br>(Month, Da  | y, Year)                    | Cour                           | * *  |
| 5.0 to            | Director  |                      | 220–16–655<br>Usual Residence of Dece                  | 59 1                                  |  | 81                  |                       |  |                                     | ļ                 |                    | OCT. 3                         | 0,1925                      | MA MA                          | RYLAND   |
|                   | nand<br>ow<br>at  |                      |  | County                                |  | 10c. City           | , Town or Lo          | cation                                 |                                     |                   |                    |                                |                             | 1                              | 0d. Inside City Limits                         |
|                   | Mary<br>Fred a  | tor                  | wv   | MINERAI                               | _  | KI                  | EYSER                 |  |                                     |                   |                    |                                |                             |                                | 1 ☐ Yes 2 No                                   |
|                   | h the   | Director             | 10e. Street and Number                                 |                                       |  |                     |                       | 10f. Zip                               | Code                                |                   | _                  |                                | 10g. Citizen                | of What Cour                   | ntry?  |
|                   | th wit<br>23a o<br>st be  | al D                 | LIMESTONE  | ROAD. I                               | .ОТ 4½                                   |                     |                       | 2                                      | 6726                                | 5                 |                    |                                | U.S                         | S.A.                           |  |
|                   | ems<br>ems  | Funeral              | 11. Marital Status                                     | 1(0125)                               | 12. Was Decedent<br>Armed Forces         | Ever in U.          | S. 13.                |  |                                     |                   | Origin? (Spe       | cify Yes or No<br>Rican, etc.) | - 14.                       | Race - Americ<br>Black, White, |  |
| 98                | or it   |                      | 1 Never Married 2                                      |                                       | 1 Tyes 2                                 | No WW               | II                    | 1 ☐ Yes                                |                                     |                   |                    | ,                              |                             | ecify:                         |  |
| 5-0036            | 72 hours after death with the Maryland<br>natural", or items 23a or 28a-f show<br>disal Examiner must be notified at  | d by                 | 3 Widowed 4 □ E  |                                       | Year or Dates:                           | & KOR               | EA                    |  |                                     |                   |                    |                                |                             | W                              | HITE   |
| 5                 | n 72 l<br>"nat<br>edica   | Completed            | 15. L<br>(Specify on                                   | Decedent's Educ<br>ly highest grade   | cation<br>completed)                     |                     | 16a. Dece             | dent's Usua<br>kind of wo<br>DO NOT us | al Occup<br>rk done i<br>se retired | ation<br>during m | ost of worki       | ng                             | 16b. Kind o                 | of Business/In                 | dustry   |
| 2121              | within<br>iene.<br>than "   | E C                  | Elementary/Secondary                                   | (0-12)                                | College (1-4or                           | 5+)                 |                       | UCK D                                  |                                     |                   |                    |                                | TRAN                        | SPORTA                         | TION   |
|                   | filed<br>Hygi<br>other<br>ent, tl   |                      | 17. Father's Name (First,                              | Middle, Last)                         |  |                     | +1/                   | OCI D                                  | 1111                                |                   | ther's Name        | (First, Middle,                |                             |                                |  |
| <u>a</u> n        | ould be<br>Mental<br>arked o  | To Be                | ROBERT RO  | ONNIE AI                              | LDRIDGE                                  |                     |                       |  |                                     | II                | DA PEA             | ARL LOG                        | UE                          |                                |  |
| Maryland          | ę p E E   | -                    | 19a. Informant's Name/P                                |                                       |  |                     | 19b. Mailii           | ng Address                             | (Street                             | and Num           | ber or Rura        | l Route Numb                   | er, City or To              | own, State, Zip                | Code)  |
|                   | 1 and 2<br>Health a<br>tem 27 is  |                      | SHARON ST  | JTHARD /                              | / DAUGHTI                                | ER                  | P.                    | O. BO                                  | X 13                                | 303,              | KEYSE              | ER, WV                         | 26726                       | 5                              |  |
| J.e.              | es 1 s<br>of He<br>item   |                      | 20a. Method of Dispositio                              |                                       |  | 1 0                 | lace of Dispo         | sition (Nan                            | ne of<br>ther plac                  | ce)               | D                  | ate                            | 20c. Locati                 | on - City or To                | own, State                                     |
| Ē                 | Page<br>nent<br>ant: M  |                      | 1 <b>∑</b> Burial 2 □Cre<br>4 □Donation 5 □            |                                       | emoval from State                        |                     | .V.C                  | -ROCKY                                 | Y GA                                | P                 | 07/23              | /2007                          | FLI                         | NTSTON                         | E, MD  |
| Baltimore,        | permit. Pages 1 an<br>Department of Heal<br>Important: If item 2<br>any injury or other<br>once.  |                      | 21. Signature of Funeral                               | (A) (D)                               | ,  |                     |                       | 2. Name an                             | d Addre                             | ss of Fac         | ility              |                                |                             |                                |  |
|                   | 8 2 E 8 9   |                      | STONO  |                                       | Churc                                    |                     |                       | 202                                    | CREI                                | ENE S             | STREET             | HOME,<br>CUMB                  | ERLANI                      | ), MD                          | 21502  |
| 75                |   |                      | 23a. Part1. Enter the dis<br>shock, or he rt failu     | ease, or cop pli<br>ure. List on y on | cations that cause<br>le cause on each l | d the death<br>ine. | n. Do not ent         | ter the mod                            | le of dyir                          | ng, such          | as cardiac o       | r respiratory a                | rrest,                      |                                | Approximate<br>Interval Between                |
|                   | Physician   |                      | Immediate Cause (Final disease or condition            | a                                     | 02                                       | REB                 | RAL                   | 37                                     | ROL                                 | (E                |                    |                                |                             |                                | Onset and Death  2 Wlefts                      |
| 4                 | /Medical<br>Examiner  |                      | resulting in death)                                    |                                       | Due to (or as                            |                     |                       |  |                                     |                   |                    |                                |                             |                                |  |
|                   | xammer  | -                    | Sequentially list condition if any, leading to immedia | ns, b                                 | Due to (or as                            | 2 0000000           | ioneo of):            |  |                                     |                   |                    |                                |                             |                                |  |
|                   | ted<br>nsit   | nine                 | Cause (Disease or injury                               | ate                                   | Due to (or as                            | a consequ           | erice oi).            |  |                                     |                   |                    |                                |                             | -                              |  |
|                   | xecur<br>al-trar  | xar                  | that initiated events resulting in death) Last         | C                                     | Due to (or as                            | a consequ           | ience of):            |  |                                     |                   |                    |                                |                             |                                |  |
| 260               | siciar<br>buri  | Sal                  |  |                                       |  |                     |                       |  |                                     |                   |                    |                                |                             |                                |  |
| 68760,            | sath certificate be executed<br>attending physician and<br>for use as the burial-transit  | ian/Medical Examiner |  |                                       |  |                     |                       |  |                                     |                   |                    |                                | - 1                         |                                |  |
| Вох               | h cert  | M/u                  | IF FEMALE:<br>23b. Was decedent preg                   | nant 2                                | 3c. If yes, outcome                      |                     |                       | Trataula a                             |                                     |                   |                    |                                | 23d.                        | Date of delive                 | ery  |
|                   | death<br>e atten  | icia                 | in the past 12 month<br>1 ☐ Yes 2 ☐ No                 | hs?                                   | 1 ☐ Live birth<br>4 ☐ Pregnant a         | at time of de       | eath 5                | ⊒Ectopic pr<br>⊒ Other <i>(sp</i>      | egriancy<br>ec <i>ify)</i>          | /                 |                    |                                |                             | Month                          | Day Year                                       |
| P.0               | law requires that the de<br>as been signed by the a<br>2 should be detached   | Physic               | 9 ☐ Unknown  |                                       | 9∐Unknown                                |                     |                       |  |                                     |                   |                    |                                |                             |                                |  |
|                   | es the  | by F                 | Part II. Other significant                             | conditions con                        | tributing to death I                     | out not resu        | ılting în the u       | nderlying c                            | ause giv                            | en in Par         | t I.               | all a                          |                             | /                              | he cause of death?                             |
| ord               | equir<br>een si<br>ould I   |                      |  |                                       |  |                     |                       |  |                                     |                   |                    | 10                             | Yes 2.DMN                   | lo 3 ☐ Prob                    | oably 4 □Unknown                               |
| မင                | law r<br>as be<br>2 sh  | Completed            |  |                                       |  |                     |                       |  |                                     |                   |                    | 24a. Was                       |                             | 4b. Were auto                  | psy findings available<br>mpletion of cause of |
| H                 | The ate had page  | Com                  |  |                                       |  |                     |                       |  |                                     |                   |                    | perfo<br>1∐ Yes                | rmed2<br>2 No               | death?                         | 2□No   |
| /ita              | clan;<br>ertific<br>ctor,   | Be (                 | 25. Was case referred to examiner?                     | medical                               |  |                     |                       |  |                                     | 26. Pla           | ce of Death        | (Check only o                  | ne)                         |                                |  |
| or Vital Records, | hysio<br>this o   | 2                    | 1 ☐ Yes 2 ☐ √No  | Н                                     | ospital:<br>1 ☐ Inpat                    |                     | ER/Outpatier          |  |                                     | 4 14              |                    | ne 5 🗆 Resid                   |                             |                                | y)   |
| n c               | ding Physician; The lav<br>n.<br>After this certificate has<br>funeral director, page 2   | on:                  | 27. Manner of Death<br>1 Natural 5                     | Pending                               | 28a. Date of Inj<br>(Month, Da           |                     | 28b. Time o<br>Injury |  | 8c. Injur<br>Wor                    |                   |                    | 28d. Describe I                | how injury oc               | courred                        |  |
| Sio               | ttend<br>leath.<br>tor: /<br>the f  | cati                 | 2 ☐ Accident<br>3 ☐ Suicide 6 ☐                        | investigation Could not be            | no- Plans of in                          | ium. At ha          |                       | M                                      |                                     | Yes 2[            |                    | 205 1 11 11                    |                             |                                | 75   |
| Division          | or Ai   | Certification:       | 4 ☐ Homicide   | determined                            | 28e. Place of in<br>building, e          | tc. (Specify        | me, iarm, str<br>')   | eet, ractory                           | /, опісе                            |                   | -   2              | City or Tov                    | street and Ni<br>vn, State) | umper or Hura                  | al Route Number,                               |
|                   | portal<br>corrections in the series of the seri |                      | 29a, Certifier 1                                       | Certifying Phys                       | ician: To the best                       | of my know          | wledge deat           | h occurred                             | at the tir                          | me date           | and place          | and due to the                 | cause(s) and                | d manner as s                  | tated  |
|                   | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director.   | Medical              | (Check only 2  | Medical Examir                        | ner: On the basis                        | of examinat         | tion and/or in        | vestigation                            | , in my                             | ppinion, d        | leath occurr       | ed at the time,                | date and pla                | ace, and due to                | o the cause(s)                                 |
|                   | Fo the<br>within<br>Fo the<br>compl   | Me                   | 29b. Signature and title of                            | f certifier                           |  |                     |                       | 290                                    | . Licens                            | e numbe           | r                  |                                | 29d. Date si                | gned (Month,                   | Day, Year)                                     |
|                   | /   |                      | > 5.(  | how                                   | gm S                                     | 5)                  |                       |  | 1) 2                                | 56                | 38                 | 9                              | 2,0                         | 4 27                           | 2007   |
|                   | 7/104   |                      | 30. Name and address of                                | f person who co                       | mpleted cause of                         | death (Item         | 23a) (Type,           | Print)                                 |                                     |                   |                    |                                | Jun                         | 72                             | 1  |
|                   | nes   |                      | SATURNI  | NA C                                  | 11 4 31 00 1                             | 4.9                 |                       | ordi                                   | va                                  | 7 F/              | rostl              | oung de                        | ary le                      | und 2                          | 1532   |
|                   | Sta   |                      | 31. Date filed (Month, Da                              | Min                                   |  | rar's Signa         | ture                  |  |                                     |                   |                    |                                | ,                           |                                |  |
|                   | Registr   | ar                   |  | 1 2 7 7                               | 107                                      | · · · · ·           | H                     | Aca. H                                 |                                     |                   |                    |                                |                             |                                |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Hobert Bowden Jack /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Peninsula NICOMICO egional Medical Center Birthplace (State or Foreign Country) Age (In yrs. last birt Date of Birth (Month, Day, Year) **Funeral** Months Days 1**⊠**M 2□ F 63 9-9-1943 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Martel Hygien.
Important: If item 27 is marked other than "natural" or items 23a or 28a-f st Important: If item 27 is marked other than "natural" or other traumatic event, the Medical Examiner must be notified any injury or other traumatic event, the Medical Examiner must be notified. Director Hccomac K Chincoteague VΑ 10f. Zip code 10g. Citizen of What Country? 10e. Street and Number ط3333 ھ 13000 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Armed Forces: 1 Types 2 □ No If Yes, Give Year or Dates: 1962-1864 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) acilities U.S. Fish and Wildlife Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bowden N, Vancy Watson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Side Rd. Chince trage, VA & 855 Ann Bowden Wifz Billie 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State Brynolds 8/1107 Chincotcague, UA 4 Donation 5 Other (Specify) d S Cemetery 22. Name and Address of F cility 21. Signature of Funeral Service Licensee Chincoteague, UA 23336 amanda C-Botto Solver Funeral Home, Inc. 6327 Church St 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 54stouc **Physician** /Medical Due to (or a consequence of): Examiner espivator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pulmonary Disease attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed MYONIZ Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Vena autopsy performe death? 1 ☐ Yes Decubita 2□ No neumonia 1∐ Yes 2 7 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month De

O Name and address of person who completed cause of death (Item 23a) (Type, Print) HAMLETTE, M.D. 100 E STEVEN

32. Registrar's Signature

rroll St. Salisbury M

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene?

|               |   | •                | For<br>State<br>Registrar  | state of Maryland   |                            | rtificate of I   |                             |                                 | eg. No.                           | 7 26211   |  |  |
|---------------|---|------------------|--|---|----------------------------|--|-----------------------------|---------------------------------|-----------------------------------|---|--|--|
|               | Physicia  |                  | 1. Decedent's Name (First, Middle, Last) Cindy   |   |                            | Beck   |                             | 2. Date of Deat<br>Month        | th Day Ye 28 201                  |   |  |  |
|               | /Medic<br>Examin  |                  | 4a. Facility Name (If not institution, give street Baltimore Washingto                       |   | nter                       | 4b. City, Town, or   | Location of Death           | 0.00                            | 4c. County of Death Anne Arundel  |   |  |  |
|               | Funeral<br>Director   |                  | 5, Social Security Number 6. Sex   | 7. Age (In vrs. la.   |                            |  |                             | 8. Date of Birth (Month, Day,   | , Year) 9.                        | Birthplace (State or Foreign<br>Country)<br>(Iaryland               |  |  |
|               | yland<br>now<br>at  |                  | Usual Residence of Decedent  10a. State 10b. County  | 7.  | Town or Lo                 |  |                             |                                 |                                   | 10d. Inside City Limits   |  |  |
|               | e Mar<br>Ba-f sl  | ctor             | MD Anne Arundo   | er Cr   | ownsv:                     |  |                             |                                 | 1 Yes 2 No                        |   |  |  |
|               | with the  | Funeral Director | 10e. Street and Number<br>1253 Generals High   | 7937  |                            | 10f. Zip Code 2103   | 2                           | 1                               | 10g. Citizen of What Country?     |   |  |  |
|               | ns 23   | neral            |  | . Was Decedent Ever in U.S.   | . 13.                      | Was Decedent of H  |                             | ecify Yes or No-                | USA<br>14. Race - A               | American Indian,  |  |  |
| 5-0036        | urs after o<br>al", or Iter<br>Examiner   | þ                | 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced                                       | Armed Forces? 1 ☐ Yes ②XXNo If Yes, Give Year or Dates:   | 1                          | if Yes, specify Cuba<br>1 □ Yes 2 <mark>X</mark> No                        | Specify:                    | Hican, etc.)                    | Specify:                          | White, etc. White   |  |  |
| 1215-0        | be filed within 72 hours after death with the Maryland<br>ntal Hygiene.<br>ed other than "natural", or Items 23a or 28a-f show<br>event, the Medical Examiner must be notified at | Completed        | 15. Decedent's Educa<br>(Specify only highest grade of<br>Elementary/Spc2ndary (0-12)        | tion<br>ompleted)<br>College (1-4or 5+)   | (Give<br>life. l           | dent's Usual Occup<br>kind of work done<br>DO NOT use retired<br>a1 Design | during most of worl<br>d)   | sing                            | 16b. Kind of Busine Florist       | ·   |  |  |
| о<br>О        | filed v<br>Hygie<br>other t   | ပ္ပိ             | 17. Father's Name (First, Middle, Last)  |   |                            |  | 18. Mother's Nam            | e (First, Middle, I             | Maiden Surname)                   |   |  |  |
| /lan          | 2 should be filed<br>and Mental Hygi<br>Is marked other<br>aumatic event, ti  | To Be            | Nelson   | Lute  |                            |  | Dolore                      | -                               |                                   |   |  |  |
| Maryland 2121 | ges 1 and 2 should<br>t of Health and Mer<br>if item 27 is marke<br>or other traumatic  |                  | 19a. Informant's Name/Relationship (Type<br>Karl Beck  | Spouse  | 1253                       | Generals   | Highway                     |                                 | r, City or Town, Sta<br>ille,MD 2 |   |  |  |
| Baltimore,    | Pages 1 and of He   |                  | 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify) | noval from State 20b. Pla   |                            | osition (Name of<br>matory or other place<br>ematory                       | i .                         | <b>/07</b> 1                    | 20c.Location - City<br>Baltimore  | ,MD   |  |  |
| Balti         | permit. Page<br>Department<br>Important: if<br>any injury o   |                  | 21. Signature of Funeral Service License   | 1   | Ha                         | 2. Name and Addre<br>ardesty F   | ss of Facility<br>uneral Ho | ome P.A.                        | 12 Ridge<br>apolis,M              | 3 <sup>1</sup> ≱1 <del>4</del> 8°                                   |  |  |
|               | al.   |                  | 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one            | tions that caused the death. cause on each line.  |                            |  |                             |                                 |                                   | Approximate<br>Interval Between<br>Onset and Death                  |  |  |
|               | Physician (Madical  |                  | Immediate Cause (Final disease or condition resulting in death)                              | Hepatore  | noe                        | L Jees.  | lure                        |                                 |                                   | 3 weeks   |  |  |
|               | /Medical<br>Examiner  |                  |  | Due tN(or as a conseque   | ence of):                  | 2  |                             |                                 |                                   | Year 1  |  |  |
|               |   | ner              | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury               | Due to (v as a conseque   | consequence of: alchochen. |  |                             |                                 |                                   |   |  |  |
|               | ecutec<br>and<br>-transi  | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last                      | Due to (or as a conseque  | ence of):                  | UUNO   | 20181                       | . 4                             |                                   | years.  |  |  |
| 68760,        | ficate be executed<br>rphysician and<br>s the burial-transit  | ä                |  | Due to (or as a conseque  | 31100 01).                 |  |                             |                                 |                                   |   |  |  |
| _             | tificate<br>g-physas the  | ledical          | 4  |   |                            |  |                             |                                 | 1                                 |   |  |  |
| O. Box        | The law requires that the death certificate be executed tte has been signed by the attending physician and hage 2 should be detached for use as the burial-transit                | Physician/M      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes → No 9 ☐ Unknown        | b. If yes, outcome pf pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown | death 3[                   | □Ectopic pregnanc<br>□ Other (specify) _                                   | у                           |                                 | 23d. Date o<br>Month              |   |  |  |
| P.<br>0.      | that the ed by the detach   | Phy              | Part II. Other significant conditions contr  | ibuting to death but not result   | ting in the u              | inderlying cause giv   | ren in Part I.              | 23e. Did to                     | bacco use contribu                | ite to the cause of death?  |  |  |
| rds           | w requires that the de<br>been signed by the<br>should be detached  | d by             | Throat (   | ance-   |                            |  |                             | 1 □ Y                           | es 2 □ No 3[                      | Probably 4 Inknown  |  |  |
| Records,      | ne law re<br>has bee<br>ge 2 sho  | Completed        |  |   |                            |  |                             | 24a. Was a<br>autops<br>perfor  | sy prio                           | re autopsy findings available<br>r to completion of cause of<br>th? |  |  |
| Vital         |   |                  | 25. Was case referred to medical   |   |                            |  | 26 Place of Dec             | 1 Yes                           | 2 No 1                            | Yes 2□No  |  |  |
|               | ulng Physician; The In. After this certificate hatfuneral director, page  | To Be            | examiner?  | spital: → Nnpatient 2 □ E   | R/Outpatier                | nt 3 DOA Oth   | or:                         |                                 | lence 6 Other                     | (Specify)   |  |  |
| 0<br>U        | ng Ph<br>fter th<br>ineral  |                  | 27. Manner of Death  1 Natural 5 □ Pending   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time o<br>Injury      | of 28c. Inju   | ry at<br>rk?                | 28d. Describe h                 | ow injury occurred                |   |  |  |
| Division or   | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director.                 | Certification:   | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined                      | 28e. Place of injury - At hom building, etc. (Specify)  | ne, farm, str              |  | Yes 2 □ No                  | 28f. Location (S<br>City or Tow | Street and Number on, State)      | or Rural Route Number,  |  |  |
| Ω             | To the Hospital of within 24 hours af To the Funeral Decompletely filled in   |                  |  | cian: To the best of my knower: On the basis of examinati   |                            |  |                             |                                 |                                   |   |  |  |
|               | the Horin 24 the Fu   | Medical          | one)   | and manner stated.  | and the                    | 29c. Licens  |                             |                                 |                                   |   |  |  |
|               | 5 # 5 P   | W                | 29b. Signature and title of certifier ave  | AL DUN TELL   | U96                        | 200  | 4973.                       |                                 | 29d. Date signed (A               | 9 2007  |  |  |
| ,             | 17 10gg   | Y -              | 30. Name and address of person who com   | pleted cause of death (Item :   | 23a) (Type,                | Print) - O 1/  | som L/                      | 2 Anip                          | 202                               | Cen Berrio  |  |  |
| -             | * 1 1 ·   |                  | Givenzer. S.S  | ALDMOUT   | MO                         | 525#6  | DS1189                      | OTIV                            | - M.                              | 021061  |  |  |
|               | Sta   |                  | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signati   | ure                        |  |                             |                                 |                                   |   |  |  |

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|  |  |                | 1 - For<br>State<br>Registrar  | State of M  | arylar                         |                                  |  |                    | lealth a<br>Death          |                                  |  | iene                           | 07                           | 26212  |
|--|--|----------------|--|---|--------------------------------|----------------------------------|--|--------------------|----------------------------|----------------------------------|--|--------------------------------|------------------------------|--|
| 8  | Physici  |                | 1. Decedent's Name (First, Middle, Las<br>Beulah Sunderland  | •   |                                |                                  |  |                    |                            |                                  | 2. Date of Dea<br>Month<br>July            |                                | Year<br>2007                 | 3. Time of Death  10:25 A <sup>M</sup>             |
|  | /Medi<br>Examir  |                | 4a. Facility Name (If not institution, give  |   |                                |                                  | 4b. City   | Town, or           | Location of                | of Death                         | July                                       |                                | ty of Death                  | 10:25 A  |
|  |  |                | Calvert Manor Head   | ethcare co  | enter                          | L                                | 1  | Risir              | ig Sui                     | ı                                |  |                                | Cecil                        |  |
| 200  | Funeral<br>Director  |                | 177-12-0017  | х<br>⊐м 2 <b>(Х</b> (F  | e (In yrs.                     | last birthday)<br>Yrs.           | If Unde<br>Months  | Days               | If Under<br>Hours          | 24 Hrs.<br>Min.                  | 8. Date of Birth<br>(Month, Day<br>Feb. 10 | Year)<br>, 1922                | 9. Birthe<br>Cour<br>Penn    | olace (State or Foreign<br>ntry)<br>Sylvania       |
|  | and<br>and   |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. Ci                        | ty, Town or Lo                   | ocation  |                    |                            |                                  |  |                                | 1                            | Od. Inside City Limits                             |
|  | Maryi<br>I sho   | jo             | Maryland Co  | ecil  |                                | Rising                           | Sun  |                    |                            |                                  |  | 1 □ Yes 2 X N                  |                              |  |
|  | r 28a  | Director       | 10e. Street and Number   |   | 1                              | Koschy                           |  | p Code             |                            |                                  | 1  | 0g. Citizen o                  | f What Cour                  | ntry?  |
|  | th with  | ai D           | 1881 Telegraph Roc   | ıd  |                                |                                  |  | 21                 | 911                        |                                  |  | USA                            | (                            |  |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or Itema 23a or 28a-1 ahow any injury or other traumatic event, the Modical Exeminar must be notified at any migra. |  | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  | 12. Was Decedent<br>Armed Forces?<br>1 Yes 2X<br>If Yes, Give<br>Year or Dates: |                                |                                  | Was Decedent of Hispanic Origin? (Specify Ye<br>If Yes, specify Cuban, Mexican, Puerto Rican, o<br>1 □ Yes ※ No Specify: |                    |                            | ecify Yes or No-<br>Rican, etc.) |  | ace - Americ<br>lack, White,   |                              |  |
| Baltimore, Maryland 21215-0036   | thin 72 ho<br>e.<br>en netur   | Completed      | 15. Decedent's Ed<br>(Specify only highest grad<br>Elementary/Secondary (0-12)   | ucation<br>de completed)<br>College (1-4or !                                    | 5+)                            | life.                            | kind of we<br>DO NOT L   | ork done           | during mos                 | t of worki                       |  |                                |                              |  |
| 2  | led wi<br>lygien<br>her th   | Con            | 9  |   |                                | Cle                              | rk   |                    | 10.11.11                   |                                  | (F) . 14(4)                                |                                | isactu                       | ring   |
| and  | ntal H<br>ed otl   | Be             | 17. Father's Name (First, Middle, Last)  Robert L. Sunderlo  | und   |                                |                                  |  |                    |                            |                                  | (First, Middle, i                          | Maiden Sum:                    | ame)                         |  |
| ž  | should<br>ind Men<br>a marke<br>umatic   | ဥ              | 19a. Informant's Name/Relationship (7  |   |                                | 19h Maili                        | na Addres  | s /Street          |                            |                                  | Rhodes                                     | City or Tow                    | m State Zin                  | Code   |
| e, Ma  | 1 and 2 s<br>Health an<br>em 27 is<br>ther traus   |                | Dorothy L. Linn/Na<br>20a. Method of Disposition   |   | 20h I                          |                                  | Cher   | ingt               |                            | ive,                             | Harris                                     |                                | PA 17                        | 110  |
| nor  | Pages<br>nent of t<br>int: If it   |                | 1 XBurial 2 X Cremation 3 □  |   |                                | cemetery, cre                    | matory or  | other plac         | · 1                        |                                  |  |                                |                              |  |
| 를  | artme<br>ortani<br>injury  |                | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service   |   | - B)                           |                                  |  |                    |                            |                                  |  |                                |                              | Maryland   |
| Ba   | permit.<br>Departr<br>Imports<br>any inju  |                | 1 pc fr  | /   |                                | R                                | 1, T.  | Foar               | d Fur                      | ieral                            | Home,<br>Risin                             | P.A.                           | un a                         | 1011   |
| *  | Physician  |                | 23a Part1. Enter the disease, or compositions, or heart dilure. List only of immediate Causa Final disease or condition                                    | lications that caused<br>the cause on each li                                   |                                | 50 110, 011                      | tor the me   | ao or ayırı        | 9, 30011 03                | our diao c                       | i rospiratory arr                          | 031,                           |                              | Approximate Interval Between Onset and Death  UCCC |
| 10 m   | /Medical<br>Examiner   |                | resulting in death)  | Due to (or as   | a consec                       | quence of):                      |  |                    | J 36 C                     | <u>G</u> (re                     | (004)04(4                                  | . Or 3e                        | Z 3C                         | Maure  |
| 8760,  | icate be executed physician and s the burial-transit   | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as  C. Due to (or as  d.   | a consec                       | quence of):                      |  |                    |                            |                                  |  |                                |                              | 7  |
| .O. Box 6  | The law requires that the death certifics ate has been signed by the attending pt page 2 should be detached for use as it  | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant at<br>9 □ Unknown        | 2 Feta                         | al death 3                       | ⊒Ectopic p<br>⊒ Other (s   |                    | ,                          |                                  |  | 1                              | Date of delive               | ery<br>Day Year                                    |
| ٥.   | s that<br>ned b<br>e deta  | by Pt          | Part II. Other significant conditions co   | intributing to death b  | ut not res                     | sulting in the u                 | inderlying   | cause give         | en in Part I               |                                  | 23e. Did to                                | bacco use co                   | ntribute to the              | ne cause of death?                                 |
| rds  | w requires<br>been sign<br>should be   | q pa           | Dementio   | OF A  | 12h                            | einer                            | 5 Ty   | pe                 |                            |                                  | 1 🗆 Y                                      | 9s 2 <b>0</b> No               | 3 ☐ Prob                     | ably 4 □Unknown                                    |
| 900  | law requas been 2 should   | Completed      |  |   |                                |                                  |  | 7                  |                            |                                  | 24a. Was a                                 |                                | . Were auto                  | psy findings available<br>mpletion of cause of     |
| Ě  | The lay<br>ate has<br>page 2   | E O            |  |   |                                |                                  |  |                    |                            |                                  | autops<br>perfor                           | med?<br>2 ☐ No                 | death?                       | 2□ No  |
| ita  | cian:<br>ertific<br>ector,   | Be (           | 25. Was case referred to medical examiner?   | A MILES IN CO.  |                                |                                  |  |                    | 26. Place                  | of Death                         | Check only or                              |                                |                              |  |
| <u>&gt;</u>  | hyaid<br>this co   | မ              | 1 ☐ Yes 2 No   | Hospital:<br>↑ ☐ Inpatie  |                                | ER/Outpaties                     |  |                    | 46140                      | irsing Hoi                       | me 5 ☐ Reside                              | ence 6 □C                      | ther (Specif                 | y)   |
| Division of Vital Records,   | ath.<br>rr: After t  | ation:         | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  | 28a. Date of Inju<br>(Month, Da   | iry<br>Year)                   | 28b. Time o                      | f<br>M   | 28c. Injun<br>Worl | yat<br>k?<br>Yes 2 □       | -                                | 28d. Describe how injury occurred          |                                |                              |  |
| Divis  | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page | Certification: | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | 28e. Place of Inj<br>building, et   | ury - At h<br>c. <i>(Speci</i> | ome, farm, st                    | reet, factor   | y, office          |                            |                                  | 28f. Location (S.<br>City or Tow           |                                | nber or Rura                 | al Route Number,                                   |
|  | To the Hospital<br>within 24 hours<br>To the Funaral<br>completely filled  | Medicai        | 29a. Certifier 1X Certifying Phyone) 2 Medical Exam  | rsician: To the best<br>iner: On the basis of<br>and manner st                  | t examina                      | owledge, deat<br>ation and/or in | h occurred<br>vestigation  | at the tin         | ne, date an<br>pinion, dea | d place, a<br>th occurr          | and due to the c<br>ed at the time, d      | ause(s) and i<br>ate and place | manner as s<br>e, and due to | tated.<br>o the cause(s)                           |
|  | To the To the Comp   | Σ              | 29b. Signature and title of certifier  | 7   |                                |                                  | 29   | c. Licensi         | e number                   |                                  | 2  | 9d. Date sign                  | ned (Month,                  | Day, Year)   |
| 1  |  |                | roul E. K  | t   |                                |                                  | $\mathcal{L}$  | 000                | 5835                       | -4                               |  | 3116                           | 7                            |  |
|  | .~   |                | 30. Name and address of person who o   | ompleted cause of o   | death (Ite                     | m 23a) (Type,                    | Print)   |                    |                            |                                  |  |                                |                              |  |
|  | 5  |                | Weil E. Lattin M.  | 32. Registr   | PNIA                           | Luky                             | (Kis   | Cris               | Jun                        | , V                              | NO 3                                       | (911                           |                              |  |
|  | Sta<br>Registi   |                | 31. Date filed (Month, Day, Year)  AUG 1   | 2007  | ars sign                       | A. J                             | doard  |                    |                            |                                  |  |                                |                              |  |

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BOYD **Physician** MABEL LILLIAN /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FAHRNEY KEEDY HOME - VILLAGE BOONESBORD WASHINGTON 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1□M 2ØF Days 215-20-8877 Director 30,1920 June Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show event, the Madical Examiner hast be notified at Md. WASHINGTON Director 1 ☑Yes 2 ☐ No HAGERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Itams 23a or JEFFERSON ST. 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō Maryland 21215-0036 1☐ Yes 2☑ No þ Specify: BLACK 3 Widowed 4 □ Divorced "natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. COCA - COLA Elementary/Secondary (0-12) College (1-4or 5+) BOTTLE IN SPECTOR PLANT 12 TH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of NHOL HARVEY GRACE TAYLOR 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21740 SYLVIA of Health a BELL 559 JEFFERSON STADT 3 HAGERSTOWN MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ò permit. Page Department of Important: If any Injury or once. WAYMAN AME CH. CAM. Aug 2, 2007 MT. PHLASANT MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility & ARY L. POLLIUS FU. Itum C My X. 110 WEST SOUTH ST PREDERICK MP 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician restate Carcinona Cecum 1 month /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease of the Causs) Physician/Medicai Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Causs (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? machilles 1 ☐ Yes 2 ☐ No 3 Probably 4 Hinknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 Lyo 1 Inpatient 2 ER/Outpatient 3 DOA harel Diractor: After the filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Alatural 5 Pending death, 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 24 hours a 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical within 24 ho To the Fund 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TELL MD JULY 27 2000 D (8019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VASANT DATTH MO 3 40 MILL ST HAGERSTOWN MO 21740 31. Date filed (Month, Day, Year) State **0 1** 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|            |  |                | 1- For Amend Item #18 Registrar WCHD/SH 8/8  | State of Ma  | aryland / D                                 |                                 | ent of H  |                                     | Mental Hy  | C3 C                                 | - 25, may  | 000                          |                |
|------------|--|----------------|--|--|---|---------------------------------|---|-------------------------------------|--|--------------------------------------|--|------------------------------|----------------|
|            | n 15:  | 1996           | 1. Decedent's Name (First, Middle, Last  |  | Н   | Oei tiiio                       | ale UI L  | Jeani                               | 0 Date of D  | Reg. No.                             |  | 257                          | 1              |
|            | Physici  | an             |  |  |   |                                 |   |                                     | 2. Date of De Month                                    | Day                                  | Year   | 3. Time of Do                |                |
| ų,         | /Media   |                | Egidio Anthony BO  |  |   |                                 |   |                                     | July   |                                      |  | 209                          | Ам             |
| )          | Examin   | er             | 4a. Facility Name (If not institution, give  | , and the second   |   | 4b. C                           | ity, Town, or                                     | Location of Dea                     | ath •  | 4c. County                           |  | 1                            |                |
| À,         |  |                | Washington County  |  | 4   |                                 | Hage  | ersta                               |  |                                      | Shing  | ton                          |                |
| П          | Funeral  |                | 5. Social Security Number 6. Se  | x<br>MI 2□F  | e (In yrs. last birti                       | rs. Monti                       | der 1 Year  | If Under 24 Hr<br>Hours Mir         |  | rth<br>a <i>y,</i> Yea <i>r)</i>     | 9. Birthplac<br>Country                            | e (State or F                | oreign         |
|            | Director   |                | Usual Residence of Decedent  |  | 83  | 15.                             |   |                                     | Sept.  | 2 1923                               | New `  | York                         |                |
|            | and and  |                | 10a. State 10b. County   |  | 10c. City, Town                             | or Location                     |   |                                     |  |                                      | 10d  | Inside City                  | limite         |
|            | //any  | ō              | M. 1 1 11  |  | _   |                                 |   |                                     |  |                                      | 100.   | 1 □ Yes 2                    |                |
|            | the f  | Directo        | Maryland Washing  10e. Street and Number   | ton  | Boon  | sboro                           | 7:- CI-   |                                     |  | 10 0111 11                           |  |                              |                |
|            | a or<br>be r   | ā              |  |  |   | 101.                            | Zip Code  |                                     |  | 10g. Citizen of \                    | What Country                                       | ?                            |                |
|            | s 23   | Funeral        | 19310 Manor Churc  |  |   | 10.111 D                        |   | 713                                 |  | USA                                  |  |                              |                |
|            | item<br>item<br>ner.r  | Ë              | 11. Marital Status   | 12. Was Decedent 8 Armed Forces?   |   | If Yes, s                       | specity Cubar                                     | spanic Origin? (<br>n, Mexican, Pue | Specity Yes or No<br>rto Rican, etc.)                  | )- 14. Rad<br>Blad                   | e - American<br>ck, White, etc.                    |                              |                |
| 36         | rs afi<br>", or<br>cami  | by F           | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced   | 1 X Yes 2 ☐ N<br>If Yes, Give<br>Year or Dates: T                          | WW TT                                       | 1 ☐ Yes                         | 2 <b>X</b> No                                     | Specify:                            |  | Specify                              | /: · .   |                              |                |
| 8          | hou tura   | be             | 15. Decedent's Edu   |  |   | Donodont'o L                    | Isual Occupa                                      | tion                                |  | 405 10-4-60                          | Whit   |                              |                |
| <u>7</u>   | n 72<br>i "na<br>ledic   | ete            | (Specify only highest grad   | e completed)   |   | Give kind of                    | work done di<br>Fuse retired)                     | uring most of wo                    | orking   | 16b. Kind of Bi                      | usiness/Indust                                     | ry                           |                |
| 21215-0036 | be filed within 72 hours after death with the Maryland nta! Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Completed      | Elementary/Secondary (0-12) 12   | College (1-4or 5   | +)  |                                 |   |                                     |  | too1                                 | S. dayo  |                              |                |
|            | filed<br>Hygi<br>ther<br>int, t  | ŏ              | 17. Father's Name (First, Middle, Last)  | <u> </u>   | 10  | οτ α σ                          | lye mal   |                                     | me (First, Middle                                      |                                      | <u>-</u>   |                              |                |
| Maryland   | should be filed<br>and Mental Hygi<br>s marked other<br>umatic event, t  | To Be          | Luca Boccone   |  |   |                                 |   | Maria                               | DiBenede<br>unknown                                    | etto                                 | <i>ie)</i>   |                              |                |
| a          | 2 shc<br>and<br>is ma  | - U            | 19a. Informant's Name/Relationship (Ty   | pe. Print)   | 19b.  | Mailing Addre                   | ess (Street a                                     | nd Number or F                      | Rural Route Numb                                       | er, City or Town,                    | State, Zip Co                                      | de)                          |                |
|            | and<br>ealth<br>n 27<br>her tr   |                | Paul Boccone - Son   | n  | 19  | 310 Ma                          | nor Ch  | nurch Ro                            | oad, Boom  | asboro.                              | Md. 21   | 713                          |                |
| ore        | of H<br>of H<br>fiter  |                | 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F  | lamanal from Otata   | 20b. Place of I                             | Disposition (#                  | Name of<br>or other place                         | i                                   | Date   | 20c. Location -                      |  |                              |                |
| Ĕ          | Pages<br>nent of<br>ant: If its<br>ary or o  |                | 4 □ Donation 5 □ Other (Specify)   | ternoval from State  | Hagers                                      | town C                          | romato  | 8/                                  | 6/07   | Hagerst                              | 0.T. M   | 1                            |                |
| Baltimore, | permit. Pages 1 and 2 should<br>Department of Health and Men<br>Important: If item 27 is marke<br>any injury or other traumatic.<br>once.                                |                | 21. Signature of Funeral Service Licens  | ee .   | Hagero                                      |                                 | and Address                                       |                                     | Minnich  |                                      |  | arylai                       | 10             |
| m          | 8 9 E E 8  |                | Fred L.VS  | stal   |   | 415 E                           | . Wils  | son Blvd                            | l. Hagers  |                                      |  | 40                           |                |
|            |  |                | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or  | cations that caused  | the death. Do no                            | t enter the m                   | node of dying                                     | , such as cardia                    | c or respiratory a                                     | rrest,                               | Ap   | proximate                    |                |
|            | Physician  |                | Immediate Cause (Final disease or condition  | 0  |   |                                 | -1-   |                                     |  |                                      | Or   | erval Betweenset and Dea     | en<br>ith      |
| )          | /Medical   |                | resulting in death)  |  | Consequence of                              |                                 | MU  | RE                                  |  |                                      | _  |                              |                |
|            | Examiner   |                |  | 1  | UMONI                                       |                                 |   |                                     |  |                                      |  |                              |                |
|            |  | ू<br>जू        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury          |  | a consequence of                            |                                 |   |                                     |  |                                      |  | _                            |                |
|            | d<br>ans t   | Examiner       | Cause (Disease or injury that initiated events   | SCY  | TI COM                                      | 14                              |   |                                     |  |                                      |  |                              |                |
| Ć,         | be executer<br>ician and<br>burial-trans   | EX             | resulting in death) Last   |  | consequence of                              |                                 | <u> </u>  |                                     |  |                                      |  |                              |                |
| 3760       | flicate be executed<br>physician and<br>is the burial-trans t  | dical          |  | CLi  | STRIDI                                      | um                              | DIFF  | FICILE                              | (52  | TIS                                  |  |                              |                |
| Ö          | requires that the death certificate een signed by the attending phys rould be detached for use as the  | edi            |  |  |   |                                 |   |                                     |  |                                      |  |                              |                |
| ROX        | eath certific<br>attending p   | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant 2  | 3c. If yes, outcome p  |   |                                 |   |                                     |  | 23d Dat                              | e of delivery                                      |                              |                |
| _          | death<br>atte  | cia            | in the past 12 months? 1 ☐ Yes 2 ☐ No  | 1□Live birth<br>4□Pregnant at  | 2 ☐ Fetal death time of death               | 3 □Ectopic<br>5 □ Other         |   |                                     |  | Mo                                   |  | / Yea                        | ır             |
| J<br>Ö     | the o  | ys             | 9 Unknown  | 9□Unknown  |   |                                 |   |                                     |  |                                      |  |                              |                |
|            | w requires that the de<br>been signed by the<br>should be detached   |                | Part II. Other significant conditions cor  | tributing to death bu  | t not resulting in t                        | he underlying                   | g cause given                                     | n in Part I.                        | 23e. Did to  | obacco use contr                     | ribute to the ca                                   | ause of deat                 | h?             |
| Records,   | uires<br>sigr<br>ld be   | d by           | REWPR FA   | LURE   | NE  | ITRO                            | 0001  | 4                                   | 10   | res 2 □ No                           | 3 ☐ Probably                                       | √ 4 l□Unk                    | nown           |
| <u>o</u>   | > 0 %  | Completed      | ANEMIA   |  | 1   |                                 |   |                                     | 1  |                                      |  |                              |                |
| ě          | The law<br>ite has b   | ם              | _ KIO COOKER   |  | ,   |                                 |   |                                     | 24a. Was<br>autor                                      | osy p                                | Vere autopsy<br>prior to comple                    | findings ava<br>tion of caus | ilable<br>e of |
| _          | n: The<br>icate har,<br>page   |                |  |  |   |                                 |   |                                     | 1□ Yes   |                                      | leath?<br>□Yes 2□                                  | ] No                         |                |
| =          |  | Be             | 25. Was case referred to medical examiner?   | ospital:   |   |                                 | 04  |                                     | ath (Check only o                                      | ne)                                  |  | <u>.</u>                     |                |
| >          | Phys<br>r this<br>ral dir  | 2              | 1 162 25 140   | . 1 Inpatier   | nt 2 ER/Outp                                |                                 |   | 4 Li Nursing i                      | Home 5 ☐ Resid   |                                      |  |                              |                |
| _          | e e  | ä              | 27. Manner of Death  1 ☑ Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day   | y 28b. Tir<br>Year) Inji                    | ıry                             | 28c. Injury a<br>Work?                            |                                     | 28d. Describe h  | now injury occurr                    | ed   |                              |                |
| _          | <u> </u>   |                | 2 ☐ Accident investigation   |  |   | М                               |   | es 2 □ No                           |  |                                      |  |                              |                |
| _          | ttending<br>Jeath.<br>tor: Afte<br>the fun   | cati           | - Condont  | 00 -   |   |                                 |   |                                     | 28f. Location (S                                       | Street and Number                    |  |                              |                |
| _          | or Attending<br>ifter death.<br>Sirector: Afte<br>in by the fun  | rtificati      | 3 Suicide 6 Could not be 4 Homicide determined   | 28e. Place of injurbuilding, etc.  | ry - At home, farn<br>. <i>(Specify)</i>    | i, street, facti                | ory, office                                       |                                     | City or Tox  | vn, State)                           | er or Hu <b>ra</b> l Ho                            | ute Number                   | ,              |
| _          | pital or Attending urs after death.  aral Director; Aftilled in by the fun   | Certification: | 3 Suicide 6 Could not be 4 Homicide determined   | building, etc.   | (Specify)                                   |                                 | •   |                                     | City or Tou  | vn, State)                           |  |                              | ,              |
| _          | Hospital or Attendin, 24 hours after death. Funeral Director; Aft tely filled in by the fun  |                | 3 Suicide 4 Homicide  29a. Certifier (Check only)  3 Suicide 6 Could not be determined                               | building, etc.   | (Specify)  f my knowledge, examination and/ | leath occurre                   | ed at the time                                    | e, date and plac                    | City or Tox  | vn, State)                           | nner ae etator                                     | 1                            | ,              |
| _          | o the Hospital or Attendin,<br>thin 24 hours after death.<br>• the Funeral Director: Aft<br>mpletely filled in by the fun  | edical         | 3 Suicide 4 Homicide  6 Could not be determined  29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin | building, etc.   | (Specify)  f my knowledge, examination and/ | death occurre<br>or investigati | ed at the time<br>on, in my opi                   | inion, death occ                    | City or Tow<br>e, and due to the<br>urred at the time, | cause(s) and ma<br>date and place, a | nner as stated                                     | d.<br>cause(s)               | ,              |
| _          | ital or Atteners after deathral Director:  | edical         | 3 Suicide 4 Homicide  29a. Certifier (Check only)  3 Suicide 6 Could not be determined                               | building, etc.   | (Specify)  f my knowledge, examination and/ | death occurre<br>or investigati | ed at the time<br>on, in my opi<br>29c. License r | inion, death occ<br><br>number      | City or Tow<br>e, and due to the<br>urred at the time, | cause(s) and ma<br>date and place, a | nner as stated<br>and due to the<br>I (Month, Day, | d.<br>cause(s)               | ,              |
| _          | To the Hospital or Attendin, within 24 hours after death.  To the Funeral Director; Aft completely filled in by the fun  | Medical        | 3 Suicide 4 Homicide  6 Could not be determined  29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin | building, etc. ician: To the best of ser: On the basis of and manner state | (Specify)  f my knowledge, examination and/ | death occurre<br>or investigati | ed at the time<br>on, in my opi<br>29c. License r | inion, death occ                    | City or Tow<br>e, and due to the<br>urred at the time, | cause(s) and ma<br>date and place, a | nner as stated<br>and due to the<br>I (Month, Day, | d.<br>cause(s)               |                |

WH-3+1

State Registrar

DAVID ALTAKO - WIREDU 31. Date filed (Month, Day, Year)

32. Registrar's Signature

AUG 0 3 2007

DHMH 17 Rev 1/2001

251 EAST ANTIETAM ST. HALTONN, MD

07-05813

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| Robert Lee Brow  |               | Ir. State of Maryland / Department of Health and Mental F  1-For State Certificate of Death  Registrar   |  | 2007 2621  |  |  |  |  |  |
|--|---------------|--|--|--|--|--|--|--|--|
| Physicia<br>Medical Exami  | ın/           | 1. Decedent's Name (First, Middle,Last)  ROBERT LEE BROWN, JR  | 2. Date of Death<br>Month<br>July 29, 20 | Day Year   |  |  |  |  |  |
| 7  |               | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 14355 Georgia Avenue #104 Silver Spring  | th                                       | 4c. County of Death  Montgomery                                |  |  |  |  |  |
| Funeral<br>Director  |               |  |  |  |  |  |  |  |  |
| A CAMPAGATA AND AND AND AND AND AND AND AND AND AN   |               | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |  | 10d. Inside City Limits  |  |  |  |  |  |
| d<br>bow an  |               | MD Montgomery Silver Spring  | 1 5                                      | 1 Yes 2 X No   |  |  |  |  |  |
| Maryland<br>28a-f show any<br>d at once.   | Director      | 10e. Street and Number 10f. Zip Code   | 10                                       | g. Citizen of What Country?                                    |  |  |  |  |  |
| h the N<br>3a or   |               | 14355 Georgia Ave., #104 20906   | L.L.                                     | U.S.A.   |  |  |  |  |  |
| after death with the Maryland<br>'nl'', or items 23a or 28a-f sho<br>iner must be notified at once.  | Funeral       | 11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No 1 Yes 2 Yes 2 No 1 Yes 2 Y |  | 14. Race - American Indian, Black, White, etc.  Specify: Black |  |  |  |  |  |
| ours aft   | d b           | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind o   |  | 16b. Kind of Business/Industry                                 |  |  |  |  |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene I in tiem 27 is marked other than "naturial", injury or other tranmatic event, the Medical Examiner. | Completed     | Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use respectively.  9th Laborer   |  | Construction   |  |  |  |  |  |
| 15-0<br>filed v<br>Il Hygin<br>ed othe   | ပို           | , , , , , , , , , , , , , , , , , , ,  | me (First, Middle, N<br>tie B.           | ,  |  |  |  |  |  |
| 212<br>ould: be<br>Menta<br>marke<br>ic even   | To Be         | 19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number of  |  |  |  |  |  |  |  |
| MD<br>id 2 sho<br>if th and<br>in 27 is<br>aumati  |               | Regina Davis (Daughter) 606 Shelfar Pl, F  |  |  |  |  |  |  |  |
| of Hea   |               | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date 0 /7 /07                            | 20c. Location - City or Town, State                            |  |  |  |  |  |
| Baltimore, Permit: Pages 1 at Department of Hee Important: If ite  |               | 4 Donation 5 Other Specify  21. Ignature of Funeral Service Lenson  22. Name and Address of Facility  22. Name and Address of Facility   |  | Riverdale. MD  |  |  |  |  |  |
| Bal<br>permi<br>Depa<br>Impo<br>injur  | ļ             |  |  | cockville,MD 20850   |  |  |  |  |  |
| Physician  |               | 25a. Part I. Enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac failure. List only one cause on each line.  | c or respiratory arre                    | est, shock, or heart Approximate Interval Between Onset and    |  |  |  |  |  |
| /Medical<br>Examiner   | 1             | Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease  |  | Death  |  |  |  |  |  |
|  |               | or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  |  |  |  |  |  |  |  |
|  | iner          | if any, leading to immediate Due to (or as a consequence of):  |  |  |  |  |  |  |  |
| xecuted<br>1 and<br>- transit  | I Examiner    | (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.  |  |  |  |  |  |  |  |
| 0,<br>be execut<br>sician and  | edical        | UNPENDED AMENDED   |  |  |  |  |  |  |  |
| 6876<br>certificate<br>iding phy   | sician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 1 Yesperant at time of death 2 Other (Specify)  | gnancy                                   | 23d. Date of delivery  Month Day Year                          |  |  |  |  |  |
| ). Box<br>the death of<br>by the atter   | Phy           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did to                              | obacco use contribute to the cause of death?                   |  |  |  |  |  |
| P.O.   | d by          |  | 1 Yes                                    | s 2 No 3 ✓ Probably 4 Unknown                                  |  |  |  |  |  |
| Division of Vital Records, tall or Attending Physician: The law requir rs after death. After this certificate has been si led in by the funeral director, page 2 should be   | Completed     |  | 24a. Was autop                           | sy prior to completion of cause of                             |  |  |  |  |  |
| Reco   | omo           |  | perfor<br>1 <b>Y</b> Yes                 | rmed? death?<br>2 No 1 ✓ Yes 2 No                              |  |  |  |  |  |
| tal Fisian: Certific   | Be C          | 25. Was case referred to medical examiner? Hospital: 1 Inpution: 2 EP/Outnetient 3 DOA Other/ Nur  |  |  |  |  |  |  |  |
| of Vid<br>Physic<br>er this<br>eral dir  | 0             | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nur  1 V Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?   |  | Residence 6  Other: Scene                                      |  |  |  |  |  |
| OD C<br>on ath.  | tion          | 1 Natural 5 Pending (Month, Day,Year) 1 Yes 2 No   |  |  |  |  |  |  |  |
| Vision Atte  | Certification | 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.   | 28f. Location (S                         | Street and Number or Rural Route Number, City                  |  |  |  |  |  |
| Di<br>spital<br>hours a<br>neral I   | Cert          | 4 Homicide determined (Specify)  29a. Certifier 4 Contitions Physicians To the heat of my knowledge, death accurred at the time date and place a   | <u> </u>                                 |  |  |  |  |  |  |
| Divisior  To the Hospital or Attend within 24 hours after death To the Fineral Director: completely filled in by the   | ledical       | one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.   | and due to the caused at the time, date  | and place, and due to the cause(s)                             |  |  |  |  |  |
| •  | Σ             | 29b. Signature and title of certifier  29c. License number  O.C.M.E.   |  |  |  |  |  |  |  |
|  |               | 30. Nam and address of person who completed cause of death (Item 23a)  |  |  |  |  |  |  |  |
| 3  |               | Molices Pressell MD Assistant Medical Evaminer 111 Penn Street Baltimore M   | D 21201 <sup>#</sup>                     |  |  |  |  |  |  |
| St<br>Regis  | tate<br>trar  | 31. Date filed (Month, Day, Year) 9 2007  32. Reistrar's Signature  AUG 0 9 2007   |  |  |  |  |  |  |  |
|  |               |  |  |  |  |  |  |  |  |

URIGINAL

State of Maryland / Department of Health and Mental Hygiene U U

2 should be filed within 72 hours after death with the Maryian n and Mental Hygiene. I is marked other than "naturel", or Iteme 23a or 28a-f ehow reumatic event, the Madical Examinar must be notified at Baltimore, Maryland 21215-0036

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 **Physician** Cain July 28, 5:26 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Marlboro Prince George 9210 Fairhaven Ave Upper riar 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Country)

July 8, 1922 Onio 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 290-14-0320 Director 85 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes No Upper Marlboro Maryland Prince George Directo 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? U.S.A. 20772 9210 Fairhaven Ave. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Tyyes 2 □ No If Yes, Give 1 Never Married 2 Marned 1 ☐ Yes 2 🔀 No Specify: 2 If Yes, Give Year or Dates: WWII Specify: White 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Church 12 Pastor 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Nannie Coates Alfred Jennings Cain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any Injury or other traun 817 Mason Ave., Deale, Md. 20751 Daughter Lois Yates 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 3, 2007

Marvland Veterans Cemetery Cheltenham, Maryland

20640 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Williams Funeral Home, r.a.

4270 Hawthorne Rd., Indian Head, Md.

Approximate Interval Between Onset and Death 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service License 20640 M00668 23a. Part1. Enter the shock, or hear sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ailure. List only one cause of leach line. Immediate Cause (Final disease or condition **Physician** GLIOBLASTOMA MULTIFORME resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) sician and burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an hes autopsy No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2000 Other: 4 Nursing Home SAR-sidence 6 Other (Specify) ٩ 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Hospital or Attending P
 24 hours after death.
 Funeral Director: After to Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending **⊘**S⊌atural Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 24 hours a
Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) Within 2 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) weets The D23743 7-30-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Dr., Greenbelt, Md. 20770 Martin Weitz, M.D. 31. Date filed (Month, Day, Year) State AUG 0 1 Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

|                                  | 1 - State of Maryland / State Registrar  |                     | ertment of H                                |              |                      | -                            | 6             | 007   | 26217   |
|----------------------------------|--|---------------------|---|--------------|----------------------|------------------------------|---------------|---|---|
| ٠                                | Decedent's Name (First, Middle, Last)  | 001                 |   | Cairi        |                      | Date of Dea                  | eg. No.       | <del></del>                                   | 3. Time of Death                              |
| an                               | John Francis CLARK   |                     |   |              | 1                    | Month ugust                  | Day<br>03     | Year<br>2007                                  | 12:50 AM                                      |
| eal<br>ier                       | 4a. Facility Name (If not institution, give street and number)   |                     | 4b. City, Town, or                          | Location of  |                      | agusi                        |               | nty of Death                                  |   |
|                                  | Washington County Hospital   |                     | Hager                                       | stown        | 1                    |                              |               | hingt   |   |
|                                  | 5. Social Security Number 6. Sex 7. Age (In yrs. last bi   | irthday)            | If Under 1 Year                             | If Under     |                      | Date of Birth<br>(Month, Day |               | 9. Birth                                      | place (State or Foreign                       |
|                                  | 216-22-7294 <sup>1⊠M 2□F</sup> 79  | Yrs.                | Months Days                                 | Hours        |                      | 19.  14.                     |               |   | vland   |
|                                  | Usual Residence of Decedent           10a. State         10b. County         10c. City, Tow                        |                     |   |              |                      |                              |               |   |   |
| 7                                |  |                     |   |              |                      |                              |               |   | 10d. Inside City Limits  1 ☐ Yes 2 No         |
| ecto                             | Maryland Washington  10e. Street and Number  | Ha                  | gerstown                                    |              |                      |                              |               |   |   |
| ä                                | 14 Catawba Circle  |                     | 10f. Zip Code                               | L742         |                      | 1                            | 0g. Citizen o |   | intry?  |
| era                              | 11. Marital Status 12. Was Decedent Ever in U.S.   | 13 V                |   |              | gin? (Specific       | Vac or No                    | US            | A<br>ace - Ameri                              | can Indian                                    |
| Fun                              | Armed Forces?  | 13. 1               | Vas Decedent of His<br>FYes, specify Cubar  | n, Mexican   | n, Puerto Rica       | an, etc.)                    |               | lack, White                                   |   |
| by                               | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 3 ☒ Widowed 4 ☐ Divorced Year or Dates: ₩₩ II            | 1                   | ☐ Yes 2X No                                 | Specify:     |                      |                              | Spec          | cify:   | white   |
| ted                              | 15. Decedent's Education 16a   |                     | ent's Usual Occupa                          |              |                      | - 1                          | 16b. Kind of  | Business/Ir                                   | ndustry                                       |
| ple                              | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)                             | life. D             | kind of work done do<br>OO NOT use retired) | ırıng mosi   | t of working         |                              |               |   |   |
| Con                              | 12 1   | sale                | sman  |              |                      |                              | fune          | ral s   | upplies                                       |
| Be Completed by Funeral Director | 17. Father's Name (First, Middle, Last)  |                     |   | 18. Mothe    | er's Name <i>(Fi</i> | rst, Middle, I               | Maiden Surna  | ame)  |   |
| ပ္                               | Leslie E. Clark  |                     |   |              | ie Dev               |                              |               |   |   |
|                                  | l ==   |                     |   |              |                      |                              |               |   | p Code) 21539                                 |
|                                  |  |                     | Lower Ge                                    | orge         |                      |                              |               |   |   |
|                                  | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemete   | ery, crem           | sition (Name of<br>natory or other place    | ´ ;          | Date                 | _                            | 20c. Location | •   | •   |
|                                  |  |                     | Cemeter                                     |              | 8/6/07               |                              |               |   | Maryland                                      |
|                                  | 21. Signature of Funeral Service Licensee  |                     | Name and Address                            |              | LITIMI               |                              | UNERAL        |   |   |
|                                  | 23a. Part1. Enter the disease, or complications that caused the death. Do  |                     | L5 E. Wils                                  |              |                      |                              |               | Md.   | 21740 Approximate                             |
|                                  | shock, or heart failure. List only one cause on each line. Immediate Cause (Final                                  | not ente            | a the mode of dying                         | , such as    | caldiac or re        | spiratory arre               | 951,          |   | Interval Between<br>Onset and Death           |
|                                  | disease or condition resulting in death)   | 511                 | alony                                       | 151          | lune                 |                              |               |   | 2 days  |
|                                  | Due to (or as a consequence  | ,                   | ×. 1. **                                    | 1 .          | 7.                   | _                            |               |   | 2 weeks                                       |
| er                               |  |                     | cular 6                                     | 1500         | der                  |                              |               |   | Z CECKS                                       |
| Examiner                         | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                |                     |   |              |                      |                              |               |   |   |
| Ex                               | resulting in death) Last  Due to (or as a consequence  | of):                |   |              |                      |                              |               |   |   |
| dical                            | d  |                     |   |              |                      |                              |               |   |   |
| Med                              | IF FEMALE:   |                     |   |              |                      |                              |               |   |   |
| an/                              | 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death | 1 3□                | Ectopic pregnancy                           |              |                      |                              |               | ate of deliv                                  | ,   |
| sic                              | 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 ☐ Unknown   | 5□                  | Other (specify)                             |              |                      |                              |               | /lonth  | Day Year                                      |
| 占                                | Part II. Other significant conditions contributing to death but not resulting in                                   | a tha un            | darluing course siver                       | in Dani I    | _                    | OO- Did s-b                  |               |   | he cause of death?                            |
| Be Completed by Physician/Me     | Chronic Obstration   | Per                 | . 4   | J CL         |                      | 1 ✓ Ye                       |               |   | bably 4 Unknown                               |
| etec                             | Charles of the contract  | 70                  | ( voc. cory v                               | J CZ         | _                    | 12.10                        |               |   |   |
| m J                              |  |                     |   |              |                      | 24a. Was ar<br>autops        | n 24b         | <ul> <li>Were auto<br/>prior to co</li> </ul> | opsy findings available ompletion of cause of |
| ပ္ပ                              |  |                     |   |              |                      | perform<br>1 Yes 2           | ned?          | death?<br>1 ☐ Yes                             | 2 □ No  |
| Be                               | 25. Was case referred to medical examiner?  Hospital: Hospital:  |                     | Othor                                       |              | of Death (Cl         | neck only one                | е)            |   |   |
| 은                                | 1 Impatient 2 ER/Ou  | tpatient<br>Time of |   | 4 LJ Nur     |                      |                              | ence 6 □O     |   | fy)   |
| ion                              | 1 ☑ Natural 5 ☐ Pending (Month, Day Year)  | njury               | 28c. Injury :<br>Work?<br>M 1 ☐ Ye          | aı<br>es 2∐N |                      | Describe no                  | w injury occu | irrea   |   |
| fica                             | a□ Cultille 6□ Could not be  | rm. stre            |   | 29 2 🔲 [     |                      | Location (St                 | reet and Nun  | abor or Bur                                   | al Route Number,                              |
| erti                             | 4 Homicide determined 28e. Place of injury - At home, fa building, etc. (Specify)                                  | ,                   | - , <b>,</b> ,                              |              | 201.                 | City or Town                 | , State)      | noci oi riuii                                 | arriodic ryamber,                             |
| Medical Certification: To        | 29a. Certifier 1 Certifying Physician: To the best of my knowledge   | e, death            | occurred at the time                        | e, date and  | d place, and         | due to the ca                | ause(s) and r | nanner as s                                   | stated.                                       |
| edic                             | (Check only one) 2 Medical Examiner: On the basis of examination an and manner stated.                             | d/or inve           | estigation, in my opi                       | nion, deat   | th occurred a        | it the time, da              | ate and place | e, and due t                                  | to the cause(s)                               |
| Ž                                | 29b. Signature and title of certifier  |                     | 29c. License                                | number       |                      | 29                           | 9d. Date sign | ed (Month,                                    | Day, Year)                                    |
|                                  | Michael of My loral  | MO                  | 104   | 116          | 67                   |                              | 83            | . 3.  | 07  |
|                                  | 30. Name and address of person who completed cause of death (Item 23a) (   | Type, P             | rint)                                       |              | - /                  |                              |               |   |   |
|                                  | Michael Milormade Illi   | 01                  | redical                                     | Co.          | mus                  | 1/2                          | jent          | wa  | no  |
| е                                | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | 1                   |   |              | 1                    | 1.0                          | ,             |   | *   |
| r                                | AUG V COUT BORE 1.   | Llo                 |   |              |                      |                              |               |   |   |

DHMH 17 Rev 1/2001

State Registrar

SH-12+1

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Yvonne Darlene CLAPP August 3:06 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 13t F 215-44-9577 Jan. 2, 1946 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County of Health and Mental Hyglene.
Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Washington Hagerstown Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 11 W. Baltimore Street USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~ any injury or other traumatic event. 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White ģ 3 ☐ Widowed 4 🔀 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) data entry data entry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Benner Gladys Mumma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P. O. Box 134, Boonsboro, Maryland 21713 William J. Clapp, Jr. - son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 8/3/07 Hagerstown, Maryland Hagerstown Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of) Examiner Pseudomonol Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner for use as the burial-transi Vulmonory and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 62440 Hagerstown Maryland 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

Dr Kalka 251 East Antietam 5t (19H-3 31. Date filed (Month, Day, 32. Regiştrar's Signature State 03

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 9:008 M Stanley Allen Dove 2007 4a. Facility Name (If not institution, give street and number City, Town, or Location of Death 4c. County of Death Plata Medical Center -0 harles If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 € M 2 □ F Months Days Hours 217-30-7732 Maryland 1932 July 6, Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Charles Bel Alton 1 ☐ Yes 2X No 10e. Street and Number 9790 Bel Alton Newtown 10f. Zip Code 10g. Citizen of What Country? P.O. Box 216 20611 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Plumber-Foreman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Tucker Edward Lee Dove 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Ann Dove-Wife P.O. Box 216 Bel Alton, MD. 20611 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens 8-2-2007 Waldorf, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Arehart-Echols Funeral Home, P.A. M01458 P.O. Box 567 211 St. Mary's Ave. LaPlata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPS 2 w Hour Due to (or as a consequence of): ACUTE RESPIRATORY FAILUPS -Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CARCINOMA LUNG. Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed'

Physician /Medical Examiner

burial-tra

law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

"natural", or items 23a or dical Examiner must be r

the

is marked other

If item 27 or other tra

Department of Important: If any injury or

2 should be fi and Mental F

Pages 1 and 2 should

ot

Baltimore,

notified at

Director

Funeral

Completed

Be

Examiner Physician/Medical

à

Completed

Be

Certification: To

page 2

this

After

or Attending

death.

within 24 hours after death To the Funeral Director:

IF FEMALE: 23b. Was decedent pregnant

1 Inpatient

(Month, Day Year)

26. Place of Death (Check only one)

|   | 25. Was case referred examiner? 1 ☐ Yes 2 ☐ No. |                     |
|---|---|---------------------|
| I | 27. Manner of Death                             |                     |
|   | 1 Natural                                       | 5 Pending investiga |
|   | 2 Accident                                      | investiga           |

28a. Date of Injury investigation 6 Could not be determined 3 ☐ Suicide 4 Homicide

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Southern Maryland Primary Care

29c. License number カ2117

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

31. Date filed (Month, Day, Year) AUG 01 2007

M.D. Cambridge Professions | Contex 3460 old Washingtoned. Washingtoned. Washingtoned. 32. Pagistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND#1,2 Per PHY. State of Maryland / Department of Health and Mental Hygiene 1 - State 7/27/07 AACO HEALTH DEPT. CMH Certificate of Death deGraffenreid Degraffenreid 1. Decedent's Name (First, Middle, Last) 2. Date of Death July 19, 2007 Ruth **Physician** Dearafferrend 325 \*/Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Mercy Medical Center Baltimore 8. Date of Birth (Month, Day, Y Mar. 12, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 950 Months Days Hours 031-40-9748 1 ☐ M 2 🔀 F 57 Yrs MA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b County 10c. City, Town or Locetion 10d. Inside City Limits MD Anne Arundel Millersville Director 1 □Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 535 Pointfield Drive 21108 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 White þ 1 ☐ Yes 2 🖾 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Florence Sexton Be William Eben Norton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 535 Pointfield Drive, Millersville, MD 21108 James T. deGraffenreid/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Blue Hills Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State July 26, 2007 Braintree, MA 4 □ Denation ) 5 □ Other (Specify) Signature Funeral Syrvice Licensee Name and Address & Soris, P.A. Severna Park Funeral Ho Franco & Soris, P.A. Severna Park, MD 21146 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate \ause (Final Physician disease of condition resulting in death) /Medical Due to (or es a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician a use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has be rector, page 2 s autopsy 1∐ Yes 2 DN director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Hospital: 2 D 16 1\_Inpatient ٩ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DYORSY 7/19/2007 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Paul PI

DHMH 17 Rev 1/2001

State

Registrar

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JUL 2 7 2007

31. Date filed (Month, Day, Year)

popry

gistrar's Signature

Baltman

31303

|                |  |                     | 1- State of Maryland / Depa<br>State Registrar   | artment of He<br>stificate of D   |   | lental Hygie  | 2 11117  | 26221  |
|----------------|--|---------------------|--|---|---|---|--|--|
|                | Physic<br>/Medi  |                     | N = a = 4 E1 4 = -1 + 1 E  |   |   | 2. Date of Death Month  July 27,                      | Day Year   | 3. Time of Death 7:35 P <sup>M</sup>         |
|                | Exami  |                     | 4- 5- 100 - 14 - 16 - 14 - 10 - 11   | 4b. City, Town, or L  Adelphi If Under 1 Year                                     |   | 8. Date of Birth                                      | 4c. County of Death Prince Geo                                       | orge's                                       |
| ٧ لماني        | Funeral<br>Director  |                     | 219-36-2940  | Months Days   | Hours Min.  | Month, Day, Ye June 23,                               | ear) 9. Birthpi<br>Coun<br>1939 Mary                                 | lace (State or Foreign<br>try)<br>y land     |
| 036            | as 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show rother traumatic event, the Medical Examiner must be notified at | by Funeral Director | 2603 Higbee Road  11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give Year or Dates:   | 10f. Zip Code  2078 Vas Decedent of Hisp Yes, specify Cuban,                      | 33<br>panic Origin? (Sp.<br>, Mexican, Puerto<br>Specify: | Ι,  | Citizen of What County  J. S. A.  14. Race - America Black, White, e | an Indian,<br>etc.                           |
| 21215-0036     | ed within 72 ho<br>ygiene.<br>ier than "natur<br>t, the Medical I  | Completed           | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Reg  | ent's Usual Occupati<br>kind of work done dui<br>O NOT use retired)<br>Sistered N | iring most of worki                                       | ing   | E. Kind of Business/Ind  |  |
| aryland 2      | should be filk<br>and Mental H<br>marked oth<br>umatic event   | To Be (             | 17. Father's Name (First, Middle, Last)  Robert K. Kennedy   |   | Naomi C   | (First, Middle, Mai<br>atherine<br>al Route Number, C |  | Code)  |
| baitimore, mar | permit. Pages 1 and 2<br>Department of Health a<br>Important: If item 27 is<br>any Injury or other trau  |                     | Joseph R. Darner (Husband) 2603  20a. Method of Disposition  1   | Higbee Rd ition (Name of atory or other place) Crematory Name and Address         | 8-1-  | hi, MD 200<br>Date 2007<br>2007 F<br>auffer Fu        |  | wn, State                                    |
| ,00            | Physician /Medical Examiner the prival-transit the burial-transit  | dical Examiner      | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last  Luny Mass  Due to (or as a consequence of):  Emphysema  Due to (or as a consequence of):  Tobacco Use  Due to (or as a consequence of): | the mode of dying,  | such as cardiac c   | respiratory arrest,                                   |  | Approximate Interval Between Onset and Death |
| O. DOX 00      | sician: The law requires that the death certificate certificate has been signed by the attending phys rector, page 2 should be detached for use as the   | Physician/Med       |  | Ectopic pregnancy<br>Other (specify)  |   |   | 23d. Date of deliver<br>Month  | y<br>Day Year                                |
| olds, r.       | requires that t<br>sen signed by<br>rould be detac   | þ                   | Part II. Other significant conditions contributing to death but not resulting in the und   | lerlying cause given  | in Part I.  |   | co use contribute to the   |  |
| ומו חבר        | an: The law<br>tificate has b<br>or, page 2 st   | e Completed         | 25. Was case referred to medical   |   |   | 24a. Was an autopsy performed 1 Yes 2 🔀               | prior to com<br>death?   | sy findings available interior of cause of   |
| A IO HOISIAIA  | or the Pospital or Artending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page  | Certification: To B | examiner?  1   | 3 DOA Other:  28c. Injury at Work?  M 1 Yes                                       | 4 □ Nursing Hon<br>tt 2<br>s 2 □ No                       | 8d. Describe how in                                   | and Number or Rural  |  |
|                | ne Hospital<br>n 24 hours a<br>he Funeral<br>bletely filled  | edical Ce           | 29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investant manner stated.   | occurred at the time,<br>estigation, in my opin                                   | , date and place, a<br>nion, death occurre                | and due to the cause<br>ed at the time, date          | e(s) and manner as sta<br>and place, and due to                      | ited.<br>the cause(s)                        |
| )              | within To the comp.  | Σ                   | 29b. Signature and title of certifier  | 29c. License no   |   |   | Date signed (Month, Duly 31, 200                                     |  |
|                | Sta  |                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Pri Robin Gross 3800 Reservoir Road, N 31. Date filed (Month, Day, Year) 32. Pigistrar's Signature   | . W., Wasl  | hington,  | D. C.   | 20057  |  |
|                | Registra   |                     | 31. Date filed (Month, Day, Year)  AUG 0 1 2007  32. Figistrar's Signature   |   |   |   |  |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 30<sup>Day</sup> 2007<sup>Year</sup> Month. MILDRED DAVIS 1355 М /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY WMHS--MEMORIAL CAMPUS If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) NH Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 3, 1928 **Funeral** Days Hours 1□ M 2□ F Director 001-22-8203 79 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at Frederick VA Winchester 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 Manito Trail 22602 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritai Status Black White etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 r than "natural", or the Medical Exami 1 □ Yes 2 □ **X**o þ Specify: 3 ₩ Widowed 4 □ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 homemaker own home es 1 and 2 should be filed w of Health and Mental Hygier fitem 27 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles E. Moody Susan A. Fields ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Funkhouser 613 Manito Trail VA 22602 Winchester grd.daugh 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Pages 1 Department of H Important: If iter any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jones Fun. Home & Crematory 8/4/2007 Winchester VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility SCARPELLI FUNERAL ITOME, P.A. FOR JONES FUNERAL HOME, INC. 228 S. PLEASANT VALLEY ROAD, WINCHESTER, VA 22601 23a. Part1. Enter the dis shock, or heart failt medicine Cause (Final Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician LEFT CEREBRAL HEMORRHAGE diseasur condition resulting in death) few hours /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any language in a line cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? þ DVT/PE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen a 24b. Were autopsy findings evailable prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 2X No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \triangle \text{Nursing Home} \) 5 \( \triangle \text{Residence} \) 6 \( \triangle \text{Other} \( (Specify) \) 1 ☐ Yes 2 🔀 No ဥ 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 ☐ Pending investigation ithin 24 hours after death.

the Funeral Director: A simpletely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier To the Fune completely f Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

nes

State Registrar Huma Shakil, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

625 Kent Ave., Suite 304, Cumberland, MD 21502

D46346

7/31/2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** BERTIE EVELYN DAWSON 19, 10:05 P <sup>M</sup> JULY 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** MEMORIAL HOSPITAL CUMBERLAND ALLEGANY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖫 Months Hours Min. 79 Director 215-26-6950 JULY 2, 1928 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits at be notified Directo 1 ☐Yes 2 No WW MINERAL KEYSER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or items 23a HC 72, BOX 510 26726 U.S.A. Hygiene. other than "natural", or items 23s ent, the Medical Examiner must. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify à Specify. 3 NWidowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER HOME 11 marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be finance and Mental F HERBERT COLLINS FTTA VANMETER traumatic ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health and Important: If item 27 Is m any Injury or other traumonce. CATHY JUNKINS / DAUGHTER HC 72, BOX 510, KEYSER, WV 26726 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BIFRTOWN CEMETERY 07/23/2007 RAWLINGS, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrovascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-transi Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 2 **1**00 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by ate has been signed page 2 should be Replageo 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown Obstructive sease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No Hunestension

a se referred to medical examiner? certificate 1□ Yes or Attending Physician: Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No the 1 Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Hospital 1 Leave Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and tiple of certifier 29d. Date signed (Month, Day, Year) 54004 20,2007 10 ma Xa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n RS 1221 NATIONAL HIGHWAY, LAVALE, MD 21502 SHIV KHANNA, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

JUL 23

2007

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Shawn             | Lamont I  |               | 60N S<br>1- For State<br>Registrar                                | State of Maryla          |   | tment of<br>ificate of          |   | d Mental H      |                                       | eg. No.               | 00          | 7 2622  |
|-------------------|---|---------------|---|--------------------------|---|---------------------------------|---|-----------------|---------------------------------------|-----------------------|-------------|---|
| Medic             | Physicia<br>al Exami  | an/           | Decedent's Name (First, Mid     SHAWN                             | dle,Last)  LAMONT        | DODSON                                  | 1                               |   |                 | 2. Date of Dea<br>Month<br>July 25, 2 | th                    |             | 3. Time of Death<br>1656 hrs                  |
| F)                |   |               | 4a. Facility Name (if not institute 3901 Fort Armistead           | -                        | mber)                                   |                                 | 4b. City, Town, or<br>Baltimore                     | Location of Dea |                                       | 4c. County            | of Death    |   |
|                   | Funeral<br>Director   |               | 5. Social Security Number Unknown                                 | 6. Sex                   | 7. Age (In yrs. las                     |                                 | If Under 1 Year<br>Months Days                      |                 |                                       | th(MM/DD/YYY<br>21,19 | Foreign     | 1   |
|                   |   |               | Usual Residence of Decedent<br>10a. State 10b. Count              | v                        | 10c City T                              | own or Locati                   | on  |                 |                                       |                       |             | 10d. Inside City Limits                       |
|                   | and<br>show any<br>nce,   | 5             |   | Arundel                  | Too. Oity, 1                            |                                 | anover  |                 |                                       |                       |             | 1 X Yes 2 No                                  |
|                   | Maryl<br>28a-f  | Director      | 10e. Street and Number  |                          |   |                                 | 10f. Zip Code                                       | _               | . (- 1                                | 0g. Citizen of W      |             | try?  |
|                   | ith the Maryland 23a or 28a-f show notified at once.  | _             | 7554 Race   |                          |   | 1 40 101                        | 2107  |                 | S 16 - 1/ N-                          |                       | 5.A.        | latina Olash                                  |
|                   | permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.    | / Funeral     | 11. Marital Status 1 Never Married 2 X 3 Widowed 4 D              |                          | 2X No                                   | If Y                            | s Decedent of His<br>es, specify Cuban<br>Yes 2X No | , Mexican, Puer |                                       | Whi                   | te, etc.    | can Indian, Black, ${f c} k$                  |
| 7 - 17 St         | ours a  | d by          | 15. Decedent's Education (Sp                                      | Pecify only highest grad | e completed)                            |                                 | t's Usual Occupat<br>ost of working life.           |                 |                                       | 16b. Kind of B        |             |   |
| 9                 | n 72 h<br>nan "n<br>ical E  | mpleted       | Elementary/Secondary (0-12  | 2) College (1            | -4 or 5+)                               |                                 | Laborer   | DO 1401 03616   | stired)                               | Wol:                  |             |   |
| 00-               | d withi<br>giene.<br>ther the   | 01            | 17. Father's Name (First, Middl                                   | le, Last)                |   |                                 |   | 18.Mother's Nan | ne (First, Middle, I                  | l                     |             |   |
| 1215              | be file<br>ental Hy<br>arked o  | Be C          | Leon Do   | odson, Jr                |   |                                 |   | Vi              | curtis                                | L. Sir                | nms         |   |
| 1D 2              | 2 should<br>a and M<br>27 is m<br>matic e   | ٩             | 19a. Informant's Name/Relation Leon Dodsor                        |                          | ther)                                   |                                 | Address (Stree<br>Conte                             |                 |                                       |                       |             |   |
| <u>5</u>          | s 1 and<br>f Health<br>if item<br>er trau   |               | 20a. Method of Disposition  1 XBurial 2 Cremati                   |                          | 20b. Pia                                | ace of Dispos<br>ematory or oth | ition (Name of cer<br>ner place)                    | metery,         | Date                                  | 20c. Location         | - City or   | Fown, State                                   |
| timo              | tment o   |               | 4 Donation 5 Other  | Speeify:                 | Que                                     |                                 | Chapel  |                 |                                       |                       |             | le,MD<br>OME,P.A.                             |
| Ba                | permi<br>Depar<br>Impo<br>injur   | 1             | 21. Sin Sture of Funeral Service                                  | . Mo                     | meer                                    |                                 |   |                 |                                       |                       |             | MD 20850                                      |
|                   | hysician<br>Medical   |               | 23a. Part I. Enter the disease, failure. List only one caus       |                          | aused the death. [                      | Do not enter th                 | ne mode of dying,                                   | such as cárdiac | or respiratory arr                    | est, shock, or he     | eart        | Approximate Interval<br>Between Onset and     |
| the same          | xaminer   |               | Immediate Caus (Final diseas<br>or condition resulting in death)  |                          | consequence of):                        |                                 |   |                 |                                       |                       |             | Death   |
|                   |   | -             | Sequentially list conditions, if any, leading to immediate        | b                        | consequence of):                        |                                 |   |                 |                                       |                       | 1           |   |
|                   |   | Examiner      | cause. Enter Underlying Caus<br>(Disease or injury that initiated | Proto (constant          | consequence of):                        |                                 |   |                 |                                       |                       |             |   |
|                   | e be executed<br>ysician and<br>burial - transit  |               | events resulting in death) Las                                    | d                        | consequence on).                        |                                 |   |                 |                                       |                       |             |   |
| Ċ.                | be exe<br>sician<br>urial -   | dical         | UNPENDED  | AMENDED                  | _                                       |                                 |   |                 |                                       |                       |             |   |
| 6876(             | ificate<br>ng phy:<br>as the b  | ian/Me        | IF FEMALE:<br>23b. Was decedent pregnant in                       | the 23c. If yes, of      | outcome of pregna<br>irth               |                                 | tal death 3   | Ectopic pregi   | nancy                                 | 23d. Date of<br>Month |             | ay Year                                       |
| Box 6             | ne death certificate<br>the attending phy<br>ned for use as the b   | S             | past 12 months?  1 Yes 2 No 9 U                                   | 4 Pregna                 | ant at time of deat                     | _ =                             | her (Specify)                                       |                 |                                       |                       |             |   |
| o<br>O            | at the d<br>d by the<br>tached  | / Phy         | Part II. Other significant cond                                   |                          |   | sulting in the u                | inderlying cause g                                  | iven in Part I. | 23e. Did to                           | obacco use con        | ribute to t | he cause of death?                            |
| ے م               | cian: The law requires that th<br>certificate has been signed by<br>ector, page 2 should be detach  | ed by         |   |                          |   | -                               |   |                 | 11                                    |                       |             | ably 4 Unknown                                |
| of Vital Records. | aw requas been  | Completed     |   |                          |   |                                 |   |                 | 24a. Was<br>autop                     |                       |             | opsy findings available ompletion of cause of |
| Rec               | The la  | E G           |   |                          |   |                                 |   |                 | 1 🗸 Yes                               |                       | Ye          | s 2 No  |
| ta                | ysician: The<br>his certificate<br>director, page   | Be (          | 25. Was case referred to medic examiner?                          | Liconital:               |   | R/Outpatient                    |   | of Death (Chec  |                                       | Residence 6           | Othor       | Conn  |
| of C              | ding Physi<br>After this<br>funeral dir   | <u>P</u>      | 1 Yes 2 No 27. Manner of Death                                    | 28a. Date                | of Injury 2                             | 28b. Time of I                  | 0 000   | y at Work?      |                                       | how injury occur      |             | Scene   |
| io                | tendin<br>eath<br>tor: A<br>the fur   | ation         |   | nding Jul 25, 2          | 007 (                                   | 0000 hrs                        | 1_ Y  | res 2 🗸 No      | Subject dro                           | wned                  |             |   |
| Division          | pital or Attend<br>ours after death<br>leral Director;<br>filled in by the  | Certification | 3 Suicide 6 Co  |                          | e of Injury - At hom                    | ne, farm, stree                 | et, factory, office b                               | uilding, etc.   | or Town, S                            |                       |             | al Route Number, City                         |
|                   | To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b | Medical Ce    | 29a. Certifier (Check only 1 Certifying                           | Physician: To the best   | t of my knowledge<br>of examination and |                                 |   |                 | nd due to the caus                    | se(s) and manne       | er as state | d.  |
|                   | F.3 F.8   | Re            | 29b. Signature and title of certi                                 | fier and manner st       | 1                                       |                                 | 29c. License  |                 | ··                                    | 29d. Date sig         |             | th, Day, Year)                                |
| W.                |   |               | Calal   | w                        | D.                                      |                                 | 0.C.1   | И.Е.<br>        |                                       | July 26, 2            | 007         |   |
| 1                 |   |               | 30. Name and address of person Zabiullah Ali, M.D.                | Assistant Medica         | al Examiner                             | 111 Pen                         | n Street, Balti                                     | imore, MD 2     | 1201                                  |                       |             |   |
|                   | St<br>Regis   | ate<br>trar   | 31. Date filed (Month, Day Yea                                    | 9 2007 32. Rg            | strar's Signature                       | B A                             | rede  |                 |                                       |                       |             |   |
|                   | <u> </u>  |               | <del></del>   |                          |   |                                 |   |                 |                                       | DOLLE                 |             |   |

| ı | Physician |
|---|-----------|
|   | /Medical  |
|   | Examiner  |
|   |           |

**Funeral** Director

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-f ehow any Injury or other traumatic event, tro Medical Examinational by notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit

Division of Vital Records, P.O. Box 68760,

| 100                    | 1 Decedent's Name   | o (First Middle                          | Local   |   |   |   |   | by. 140.                            | 2 Time of Death  |  |
|------------------------|---|--|---|---|---|---|---|-------------------------------------|--|--|
| iciàn                  | 1. Decedent's Name  |  | _   |   |   |   | 2. Date of Deat                               | Day Y                               | 3. Time of Death   |  |
| dical                  | Samuel Ac   |  | der<br>give street and numbe                  | r)  | Ab City To                                | m, or Location of D                     |   | /2007<br>4c. County of              | 9:36am   |  |
| niner                  |   |  | give street and number                        | ')  |   |   | Death   |                                     |  |  |
|                        | 308 Halse 5. Social Security N  |  | 5. Sex 7. A                                   | ge (In yrs. last birth  |   | nnapolis<br>ear   H Under 24            | Hrs. 8. Date of Birth                         |                                     | Arundel  Birthplace (State or Foreign)                             |  |
| al<br>or               | 038-22-44   | 438                                      | 1 <b>⊠</b> M 2□F                              | 78 Yr   | Months D                                  |   | Min. 7/13/29                                  | Year)                               | Maryland   |  |
|                        | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location   |  |   |   |   |   |   |                                     |  |  |
| ৯                      |   | ,  | Arundel                                       |   |   |   |   |                                     | 10d. Inside City Limits 1 ☐ Yes �☑ No                              |  |
| Director               | MD  |  | Arunder                                       | An  | napolis                                   |   |   |                                     |  |  |
| 급                      | 10e. Street and Nur   |  |   |   | 10f. Zip Co                               |   | 1   | 0g. Citizen of Wha                  | it Country?  |  |
| ra                     | 308 Halse   | ey Rd.                                   | 140.111.5                                     |   |   | 21401                                   |   | 144.5                               | USA  |  |
| Funeral                | 11. Marital Status  | ind Wilderin                             | 12. Was Deceder                               | 1?  | If Yes, specify                           | of Hispanic Origin<br>Cuban, Mexican, F | n? (Specify Yes or No-<br>Puerto Rican, etc.) |                                     | American Indian,<br>White, etc.                                    |  |
| by F                   | 3 Widowed   | ied 2 <del>∑M</del> arrie<br>4 □Divorced | d 1 □Yes 2 ½<br>If Yes, Give<br>Year or Dates |   | 1 ☐ Yes 21X                               | No Specify:                             | Specify:                                      | White                               |  |  |
| Completed by           |   | 15. Decedent's                           |   | 16a. D  | ecedent's Usual O                         | ccupation                               |   | 16b. Kind of Busin                  | ess/Industry   |  |
| pe                     | (Spec   |  | grade completed)                              | (6  | Give kind of work of<br>ife. DO NOT use r | one during most oi<br>etired)           | f working                                     |                                     | ,  |  |
| E E                    | ciententary/3eco  | indary (U-12)                            | College (1-4o                                 |   | rofessor                                  |   |   | USNA                                |  |  |
| BeC                    | 17. Father's Name   | (First, Middle, La                       | ast)  |   |   | 18. Mother's                            | Name (First, Middle, M                        |                                     |  |  |
| To B                   | Fred King   | gsley El                                 | lder  |   |   | Eth                                     | nel Tait                                      |                                     |  |  |
| -                      | 19a. Informant's Na   |  |   | 19b. A  | Mailing Address (Si                       | reet and Number o                       | or Rural Route Number                         | City or Town, Sta                   | ite, Zip Code)   |  |
|                        | Sylvia Ma   | aynard H                                 | Elder Wi                                      | fe 308  | Halsey                                    | Rd. Anna                                | apolis, Md                                    | 21401                               |  |  |
|                        | 20a. Method of Disp   | position                                 |   | 20b. Place of D   | isposition (Name of crematory or other    | of                                      | - Andrews                                     | 20c. Location - Cit                 | y or Town, State   |  |
|                        |   | ☐ Cremation 3<br>5 ☐ Other (Spe          | 3 □Removal from Stat<br>ecify)                | 9   | ical Pre                                  |   | /1/2007                                       | Annapoli                            | s. MD  |  |
| di.                    | 21. Signature of Fu   | neral Service L                          | censee  | Dvangor   |   |   | Hardesty Fu                                   |                                     |  |  |
|                        | 175   | 1.0                                      | <b>/</b>                                      |   |   |   | Annapolis,                                    |                                     |  |  |
|                        | 23a. Part1. Enter th  | he isease, or d                          | plications that cause                         | ed the death. Do no   |   |   | rdiac or respiratory arre                     |                                     | Approximate  |  |
|                        | shock, or nea   | rt failure. List or<br>(Final            | nty one cause on each                         | 1010  |   | avcou                                   |   |                                     | Interval Between<br>Onset and Death                                |  |
|                        | disease or condition resulting in death)  | in                                       | a. Due to /ee                                 |   |   |   | 7001  |                                     | 137NS  |  |
| r                      | i   |  | Dd9 t0 (01 a                                  | s a consequence ol)   | •   |   |   |                                     |  |  |
| ē                      | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b   |  |   |   |   |   |   |                                     |  |  |
| Examiner               | fr any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  C                          |  |   |   |   |   |   |                                     |  |  |
| xar                    |   |  |   |   |   |   |   |                                     |  |  |
| 100                    |   |  |   |   |   |   |   |                                     |  |  |
| an/Medical             | d.  |  |   |   |   |   |   |                                     |  |  |
| Z/M                    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify) Month |  |   |   |   |   |   |                                     |  |  |
| _                      |   |  |   |   |   |   |   |                                     |  |  |
| nys                    | 9 ☐ Unknown   |  | 9□ Unknown                                    |   |   |   |   |                                     |  |  |
| Completed by Physic    | Part II. Other signif   | icant condition                          | s contributing to death                       | ing to death but not resulting in the underlying cause given in Part I. |   |   |   |                                     | te to the cause of death?  |  |
| d b                    |   |  |   |   |   |   | 1 □ Ye  | s 25 No 3[                          | Probably 4 Unknown   |  |
| lete                   |   |  |   |   |   |   | 24a. Was a                                    | 24h War                             | e autopsy findings available                                       |  |
| mc                     |   |  |   |   |   |   | autops<br>perform                             | ned? dea                            | e autopsy findings available<br>r to completion of cause of<br>th? |  |
| C                      | 25. Was case refer  | red to modical                           |   |   |   | 00.51                                   |   | <b>2</b> No 1□                      | Yes 2 No   |  |
| To Be                  | examiner?   |  | Hospital:                                     | ient 2 ER/Outpa   | ationt 2004                               | Other                                   | Death (Check only on                          |                                     | C  |  |
|                        | 27. Manner of Death   |  | 28a. Date of In<br>(Month, D                  |   |   | 4 🗀 (40) 311                            | ng Home 5 Reside                              | nce 6 ∐Other (<br>w injury occurred | эрвспу)  |  |
| tlor                   | 1 Natural 2 Accident  | 5 Pending                                |   | ay Yeer) Inju   | M M                                       | Injury at<br>Work?<br>1 □ Yes 2 □ No    |   | .,_,                                |  |  |
| flca                   | 3 Suicide   | 6 ☐ Could no                             | t be  | njury - At home, farm   |   |   |   | reet and Number r                   | or Rural Route Number,   |  |
| ert                    | 4 🗌 Homicide  | determin                                 | building,                                     | etc. (Specify)  |   |   | City or Town                                  | , State)                            |  |  |
| Medical Certification: | 29a. Certifier<br>(Check only   | Certifying                               | Physicien: To the besit                       | t of my knowledge, of   | death occurred at the                     | ne time, date and p                     | place, and due to the ca                      | use(s) and manne                    | er as stated.  |  |
| edi                    | 0116)   |  | and manners                                   | stated.   | investigation, in                         | ny opinion, death (                     | occurred at the time, da                      | ite and place, and                  | due to the cause(s)  |  |
| 2                      | 29b. Signature and  | tipe of certifier                        | milyu   | S   | 29c. Li                                   | ense number<br>1983                     | 8   | 7/27/                               | 1900 J   |  |
|                        | 30. Name and address  | ess of person w                          | no completed cause of                         | death (Item 23a) (Ty  | rpe, Print)                               | Bestga                                  | te Rd. F                                      | Innapo                              | is, ald.   |  |
| tate                   | 31. Date filed (Mont  | th, Day, Year)                           | 32. A gis                                     | trar's Signature  |   |   |   | -                                   |  |  |
| trar                   |   | JUL 3 0                                  | 2007  | on &  | (beat)                                    |   |   |                                     |  |  |
| /2001                  |   | - <del>-</del>                           |   |   | 7   |   |   | . ,                                 |  |  |

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** Karol Fay Evans 2007 Рм 2:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mandrin Chesapeake Hospice House Harwood Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 03/29/1944 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🗐 F Michigan Director 386-42-0999 63 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Tayes 2 TINo Directo Prince George's Maryland Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3933 Elan Court 20716 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or If Yes, Give Year or Dates: 1963-64 1 □ Yes 2 No ģ Specify: 3 ☐ Widowed 4 🕅 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Accountant Government Contracting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Claude B. Adair Emily Lucy Good ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Evans, Jr./Son 3933 Elan Court, Bowie, Maryland 20716 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Kalas Crematory 07/25/2007 | Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home ales 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 26 MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 No been signed by the s should be detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 2€No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ₩ No 24a. Was an cate has page 2 s autopsy performed? Yes 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 HOther (Specify) Hospice 1 ∏ Yes 25 No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir '<del>House</del> 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft 1 Matural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number se of death (Item 23a) (Type, Print) 30. Name and address of person who compl-JULY (34) VERL LYARL

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUL 2 7 2007

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 **Physician** WALTER **ENGLE** 07 1315 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND ALLEGANY WMHS BRADDOCK CAMPUS If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 217-28-9646 77 Maryland Director April 12, 1930 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State a or 28a-f show be notified at 28a-f show 1 Yes 2 No Director Allegany **Eckhart** Maryland 10f, Zip Code 10e. Street and Number 10g, Citizen of What Country? 103 Porter Road Pages 1 and 2 should be filed within 72 hours after death with "natural", or items 23a edical Examiner must b 21528-U.S.A by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☑Divorced conflict White Completed the Medical I 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. owner/operator meat market 27 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Lester Engle, Sr. Alice Wright ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 20837-Daniel L. Engle Maryland 19117 Dowden Circle **Poolsville** 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cumberland Crematory Cumberland Maryland July 24, 2007 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Approximate Interval Between Onset and Death YLS 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hypertensive cardiovascular disease **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, in a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) P.O. Box 68760. physician s the burial Physician/Medical SE attending I IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 TYes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has e 2 autopsy this certificate 2 No 28 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 1 1 Yes 2 □ No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🔲 Inpatient ٦ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation (Month, Day Year) Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation in the basis of examination and or investigation in the basis of examinati

Division or Vital Records, Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the i To the I

7/IVA nas

Registrar

Medical

31. Date filed (Month, Day, Year)

JUL 2 5 2007

29b. Signature and title of certifier

(Check only one)



med

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and pranner stated.

<sup>29c.</sup> License number DO 9 1 5 7

290 24 s/g0=07 (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Richard Ralph Fetters 9:00 P August 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Cumberland
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Allegany 10 N. Liberty Street, Apt 208 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** Days 1 ☑ M 2 ☐ F 68 07/13/1939 Director Maryland 214-36-6308 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifled at 1 Yes 2 No Director Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 N. Liberty Street, Apt 208 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 MYes 2 No 1956 — If Yes, Give Year or Dates: 1960 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🔀 No Specify: Specify: <u>Ş</u> 3 Widowed 4 Divorced 1960 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor <u>Municipal</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Fetters Erma Reddinger 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Annette Fetters / Wife 10 N. Liberty Street, Apt 208, Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ※ Cremation 3 Removal from State 4 ☐ Donation Other (Specify) Cumberland Crematory 08/02/2007 Cumberland, MD Fune | Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as nsequence of) Examiner Sequentially list conditions, if any learning Learning Cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-transit requires that the death certificate be executed Exami and Due to (or as a consequence of) physician Physician/Medical as the IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribate to the cause of death? 2 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 2 Accident completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

3/1VA

Maryland 21215-0036

Baltimore,

P.O. Box 68760

Division or Vital Records,

nes

State Registrar 29b. Signature and title of con

29c. License number

29d. Date signed (Month, Day, Year)

D22181

August 2, 2007

30. Name and address of person who conveted cause of death (Item 23a) (Type, Print)

M.D., Gary L. Wagoner 925 Bishop Walsh Drive, Cumberland, MD

and manner stated

31. Date filed (Month Day AUG 0

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend Item 24a per verb., g872 10/19/07/dbbath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 19,2007 9:45 p<sup>M</sup> Victor Goldberg Bernard July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heritage Harbor Health & Rehab Annapolis Anne Arundel 5. Social Security Number 086-07-7778 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours February 1919 1X M 2□ F Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show the Medical Examiner must be notified at MD Anne Arundel Millersville 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1398 Antrim Drive 21108 Funeral USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s may injury or other traumatic event, the Medical Examiner must once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No 41-46 If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Personnel Specialist Elementary/Secondary (0-12) College (1-4or 5+) US GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Goldberg Sarah Sklar ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Freeman Daughter 1398 Antrim Drive Millersville, MD 21108 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Maryland Veterans Cem 07/25/2007 Crownsville, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licons 22. Name and Address of Facility Hardesty Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 TLNG 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe certificate Be ( 25. Was case referred to examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this Director: After the 27. Manner 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? tural 5 Pending investigation 1 Tyes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier Effectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and add 31. Date filed (Month, Day, Year)

JUL 3 1 2007 State Registrar

AUG 0 2 2007

|             |                                   | 1 - State Of Will State Registrar  | Ce   | rtificate of L  |   | , ,  | g. No.  | 26230  |
|-------------|-----------------------------------|--|--|---|---|--|---|--|
| sici        | an                                | 1. Decedent's Name (First, Middle, Last)  John Howard Gill   |  |   |   | 2. Date of Death<br>Month                  | Dav Year  | 3. Time of Death                                   |
| edic<br>min |                                   | 4a. Facility Name (If not institution, give street and number)   |  | 4b. City, Town, or  | Location of Death                                     | July :                                     | 31 2007<br>4c. County of Death                  | 11:15 A M  |
|             | ici                               | Carroll Lutheran Village H   |  | Westmins  |   |  | Carroll   |  |
| rai<br>tor  |                                   | 212-28-0738 <sup>1</sup> ፟፟፟፟፟M 2□F  | ge (In yrs. last birthday)<br><b>77</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                        | 8. Date of Birth<br>(Month, Day,<br>May 5, | 9. Birth<br>1930 Mary                           | nplace (State or Foreign<br>intry)<br>land         |
| 41          |                                   | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or Lo                        | ocation   |   |  |   | 10d. Inside City Limits                            |
|             | tor                               | Maryland Baltimore   | Reisterst                                    | own   |   |  |   | 1 □ Yes 2X No                                      |
|             | al Director                       | 10e. Street and Number<br>2420 Cedarhurst Drive  |  | 10f. Zip Code 21136   |   |  | g. Citizen of What Counited State               | •  |
| 200         | by Funeral                        | 11. Marital Status  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Arried Forces?  1 △ Yes 2 □ 17 Yes, Give Year or Dates:  | No 1959-                                     | Was Decedent of Hi<br>If Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No                    | spanic Origin? (Spe<br>n, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)           | 14. Race - Amer<br>Black, White<br>Specify: Whi | e, etc.  |
|             | Completed                         | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or state)  | (Give  | dent's Usual Occupa<br>kind of work done of<br>DO NOT use retired,<br>ronic cal | luring most of workii<br>)                            | ng   | 6b. Kind of Business/I<br>Electror<br>manufact  | nics   |
|             | To Be C                           | 17. Father's Name (First, Middle, Last) Guy Kenneth Gill   |  |   | 18. Mother's Name<br>Elizabet                         |  | ,   |  |
|             |                                   | 19a. Informant's Name/Relationship (Type. Print)  Ellen E. M. Gill – wife  |  | -   |   |  | City or Town, State, Z                          |  |
|             |                                   | 20a. Method of Disposition  1 🕱 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)   |  | osition (Name of<br>matory or other place<br>ck Cemete                          | nugus   | + 6  | Oc. Location - City or Butler, Mar              |  |
| ouce.       |                                   | 21. Signature of Funeral Service Licensee  |  | 2. Name and Addres  | <sup>s of Facility</sup> El<br>Main Stre              | ine Fune<br>et Hamp                        | eral Home<br>ostead, Md.                        | 21074  |
| an<br>cal   |                                   | 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each limmediate Cause (Final disease or condition resulting in death)  a. Due to (or as   |  | ter the mode of dying   |   | or respiratory arres                       | st,   | Approximate<br>Interval Between<br>Onset and Death |
|             | al Examiner                       | cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events   | a consequence of):                           |   |   |  |   |  |
|             | Be Completed by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown  | 2 Fetal death 3                              | □Ectopic pregnancy<br>□ Other (specify)   |   |  | 23d. Date of deli<br>Month                      | very<br>Day Year                                   |
|             | ed by Ph                          | Part II. Other significant conditions contributing to death be   | out not resulting in the u                   | inderlying cause give   | en in Part I.   | 23e. Did toba                              | acco use contribute to                          | the cause of death?                                |
|             | omplet                            |  |  |   |   | 24a. Was an autopsy perform                | prior to c                                      | topsy findings available completion of cause of    |
|             | Be C                              | 25. Was case referred to medical examiner?   |  |   | 26. Place of Death                                    | -  |   |  |
| 3           | ပ္                                | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpati  |  |   | 4 Nursing Hor   | me 5 Resider                               | nce 6 Other (Spec                               | cify)  |
|             | ntion                             | 1 XNatural 5 Pending (Month, De 2 Accident investigation   | y Year) Injury                               | Work  | rat<br>res 2 □No                                      | zou. Describe nov                          | wingary occurred                                |  |
|             | ertifica                          | 3 Suicide 6 Could not be 28e. Place of in  | ury - At home, farm, str<br>c. (Specify)     | reet, factory, office   | 4   | 28f. Location (Stre<br>City or Town,       | eet and Number or Ru<br>State)                  | ral Route Number,                                  |
| formal      | Medical Certification:            | 29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st   | of examination and/or in                     | th occurred at the tin  | ne, date and place, a<br>pinion, death occurr         | and due to the ca                          | use(s) and manner as<br>ite and place, and due  | stated.<br>to the cause(s)                         |
|             | M                                 | 29b. Signature and title of certifier  • Cfunsware Int   |  | 29c. License  |   | 29   | d. Date signed (Month                           | n, Day, Year)                                      |
| A           |                                   | 30. Name and address of person who completed cause of Cause of Completed Cause of Cause o |  | olm DR  | · Ne  | stmins                                     | too m   | ) 21157  |
| Sta         | te                                | 31. Date filed (Month, Day, Year) 32. Regint   | rar's Signature                              |   |   |  |   |  |

DHMH 17 Rev 1/2001

Registrar

Physician /Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:45 P M Edythe H. Garner Ju1y 26 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 186 Lees Lane Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director 579-09-8182 95 05/08/1912 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Anne Arundel Edgewater 1 ☐ Yes 2 X No Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 186 Lees Lane 21037 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Secretary Federal Government 10 other traumatic event, Alth and Mental Hu 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked o any Injury or other traumatic man Francis E. Hoffmann Margaret E. Plantholt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Solt/Son 118 Aliso Drive, Palm Springs, California 92064 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/27/2007 | Edgewater, Maryland Kalas Crematory 21. Signature of Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home · Kales 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Audomina >10 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760. physician Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy 1 ☐ Live birth ∠ ☐ Feed 4 ☐ Pregnant at time of death Live birth 2 Fetal death in the past 12 months?

1 Yes 2 Yoo

9 Unknown Month Day Year 5 Other (specify) P.O. I signed by the a 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, by 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ► 100 24a. Was an page 2 s autopsy performe Yes 2 certificate 1□ Yes Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only onle Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Attending 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours a 1 dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

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State Registrar

JUL 2 7 2007

29b. Signature and title of pertifier

30. Name and address

completed cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number

29d. Date signed (Month, Day, Year)

Mayo Rd. Edgewater Nd 21037

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** 11408 Vale FROSTLI Social Security Number 8. Date of Birth . Age (In yrs. last birthday) Sex. 12 M 2□F (State or Floreign Funeral Months Davs Hours Director Usual Residence of Decedent 10c, City, Town or Location 10b. County 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 1 PYes 2 No Director MARYLAND Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21532 11608 VALE Summit Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mary Ses 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: 2 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Store Salesman BEDARTMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be VALENZANO Gaudio Antonio MATILAA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edella Grudio Wife. VALE Symmit Rd. FROSTBURG onD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State mt. Savage 4 Donation 5 Other (Specify) Methodist CEMRY 21. Signature of Funeral Service/Licensee 32. Name and Address of Facility Home 51 FROST AUE 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ardiac /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MON-INSULIN DEDENDENT ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 9□Unknown 5 Other (specify) ☐Yes 2☐No 9 Unknown Part I]. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2000 autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home ပ 5 Residence 6 □Other (Specify) 28b. Time of 28d. Describe how injury occurred Certification:

Division or Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Medical

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

6/IUA

nLs

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person when

JUL 2 4 2007

cause of death (Item 23a) (Type, Print) MO

1)00252910

29c. License number

29d. Date signed (Month, Day, Year) 07,23.2007

Street Cumberland, MD 21502 200 Glenn

Registrar

|                            |  |                 | For State of Mar<br>State Registrar   |                                   | artment of Heal<br>tificate of Dea   |  | ital Hygie<br>Reg                                | 200                             |                                 | 25233                                     |
|----------------------------|--|-----------------|---|-----------------------------------|--|--|--|---------------------------------|---------------------------------|---|
|                            | Physici  | _               | 1. Decedent's Name (First, Middle, Last)  David Eric Howell   |                                   |  | J. J   | Date of Death<br>Month<br><b>uly</b>             | 30                              | 2007                            | 3. Time of Death 9:00 PM                  |
| V.                         | /Medic   | _               | 4a. Facility Name (If not institution, give street and number)  |                                   | 4b. City, Town, or Loca  | tion of Death  |  | 4c. County o                    | f Death                         |   |
|                            | Funeral<br>Director  |                 |   | (In yrs. last birthday)           | Perryvill If Under 1 Year If U Months Days Ho                                    | nder 24 Hrs. 8.<br>urs Min.                          | Date of Birth (Month, Day, Y                     | ear)                            |                                 | * /                                       |
|                            | D  |                 | Usual Residence of Decedent   |                                   |  |  | CL. J,   | 1900 1.                         |                                 |   |
|                            | Marylar<br>t-f show<br>fied at   | tor             | Maryland Cecil  | Oc. City, Town or Lo Perryvi1     |  |  |  |                                 | 10                              | d. Inside City Limits<br>1 ∐Yes 2 🎇 No    |
|                            | th the or 288  | Director        | 10e. Street and Number  |                                   | 10f. Zip Code  |  | 10g  | . Citizen of Wh                 | nat Countr                      | у?  |
|                            | ath wi   | ral             | 33 Woodall Road   |                                   | 21903  |  |  | nited :                         |                                 |   |
| 36                         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatte event, the Medical Examiner must be notified at once. | by Funeral      | 11. Marital Status  1 ☐ Never Married ★★Married  3 ☐ Widowed 4 ☐ Divorced  12. Was Decedent Every Armed Forces?  1 ☐ Yes 2 ★ No If Yes, Give Year or Dates:   |                                   | Mas Decedent of Hispani<br>f Yes, specify Cuban, Me<br>I □ Yes 2√Ω No <i>Spe</i> | ic Origin? (Specify<br>exican, Puerto Rica<br>ecify: | Yes or No-<br>an, etc.)                          |                                 | - America<br>, White, et<br>Whi | tc.                                       |
| 2-0                        | 72 hou<br>'natura<br>dical E   | eted            | 15. Decedent's Education<br>(Specify only highest grade completed)  | (Give                             | dent's Usual Occupation<br>kind of work done during                              | most of working                                      | 16   | b. Kind of Bus                  | iness/Indu                      | ıstry                                     |
| 21215-0036                 | y within<br>giene.<br>r than "   | Completed       | Elementary/Secondary (0-12) College (1-4or 5+)  |                                   | NOT use retired) k Driver  |  |  | Self Er                         | mplov                           | red                                       |
| g                          | al Hyg   | Be C            | 17. Father's Name (First, Middle, Last)   |                                   |  | Mother's Name (Fi                                    |  |                                 |                                 |   |
| yla                        | ould b<br>Ment<br>narked<br>natic e  | To I            | Edward P. Howell  |                                   |  | arbara S   |  |                                 |                                 |   |
| Maryland                   | d 2 sh<br>th and<br>7 is m<br>traum  | p ŝ             | 19a. Informant's Name/Relationship (Type. Print)  Joanna M. Howell / Spouse   | 111                               | ng Address (Street and Nodall Road,  |  |  |                                 | State, Zip (<br>219             |   |
|                            | s 1 an<br>f Heal<br>ftem 2<br>other  |                 | 20a. Method of Disposition  |                                   | sition (Name of natory or other place)   | Date   | 20   | c. Location - C                 |                                 |   |
| Baltimore,                 | Page:<br>nent o<br>int: If   |                 | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  |                                   | e Crematory  | Augus 4, 200   |  | ewark,                          | Dela                            | ware                                      |
| Salti                      | epartr<br>ports<br>ny Inju   |                 | 21. Signature of Funder I Specifice Licenses  | 22                                | . Name and Address of F  | Facility Croud                                       | ch Fune  | ral Hor                         | ne                              |   |
|                            | <u>0</u> □ = 8 0   |                 | 23a. Part1. Enter the disease, or complications that caused the   |                                   | 27 South Ma  |  |  |                                 |                                 | y1and21901<br>Approximate                 |
|                            | Physician<br>/Medical<br>Examiner  | er              | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a description of the conditions)  Sequentially list conditions. | consequence of:                   | Gastric  |  |  |                                 | 1                               | Interval Between<br>Onset and Death       |
| 68760,                     | ficate be executed<br>physician and<br>sthe burial-transit   | edical Examiner | that initiated events   | consequence of):                  |  |  |  |                                 |                                 |   |
| P.O. Box                   | The law requires that the death certif<br>tte has been signed by the attending<br>age 2 should be detached for use a   | Physician/M     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tire 9 □ Unknown  | ☐ Fetal death 3☐                  | Ectopic pregnancy Other (specify)  |  |  | 23d. Date<br>Mon                |                                 | y<br>Day Year                             |
|                            | w requires that the de<br>been signed by the a<br>should be detached f   | by              | Part II. Other significant conditions contributing to death but   | not resulting in the ur           | nderlying cause given in I   | Part I.  | 23e. Did tobac                                   | _                               |                                 | e cause of death?                         |
| Division or Vital Records, |  | Completed       |   |                                   |  |  | 24a. Was an<br>autopsy<br>performe<br>1∐ Yes 2 ☐ | d? pr                           | ior to com                      | sy findings available pletion of cause of |
| <u> </u>                   | slcian<br>certifi<br>rector  | Be              | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient  | 0.55500                           | Othor  | Place of Death (C                                    |  |                                 |                                 |   |
| 0                          | g Phy<br>er this<br>eral di  | 7: To           | 27. Mann of Death 28a. Date of Injury   | 2 ER/Outpatien                    | 1 3 DOA 4  | ☐ Nursing Home 28d.                                  | 5 La Residence Describe how                      |                                 |                                 |   |
| ö                          | tending Pheath. tor: After the   | atio            | 1 Matural 5 □ Pending (Month, Day 1<br>2 □ Accident investigation   | (ear) Injury                      | M 1 ☐ Yes  | 2 🗆 No   |  |                                 |                                 |   |
| Divis                      | Il or Attent<br>after death<br>I Director:<br>d in by the  | Certification:  | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury building, etc.  | - At home, farm, str<br>(Specify) | eet, factory, office   | 28f.   | Location (Stree<br>City or Town, S               | et and Numbe<br>State)          | r or Rural                      | Route Number,                             |
|                            | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,   | ledical C       | 29a. Certifier (Check only one)  1 ✓ Certifying Physician: To the best of each manner state and manner state  | xamination and/or in              | n occurred at the time, da<br>vestigation, in my opinion                         | ate and place, and<br>n, death occurred              | due to the cau<br>at the time, date              | se(s) and man<br>e and place, a | ner as sta                      | ited.<br>the cause(s)                     |
| )                          | To the H<br>within 24<br>To the Fi<br>complete   | Me              | 29b. Signature and title of ourtifier   |                                   | 29c. License num   | s653   | 290  | Date signed                     | (Month, D                       | ay, Year)                                 |
|                            | 6  |                 | 30. Name and address of person who completed cause of deal Martha Hosto & MO 11   | 1 W. Hic                          | 1 St. SUH  | HO14   | EIKT   | on. M                           | 0 2                             | 1921                                      |
|                            | Sta<br>Registr   |                 | 31. Date filed (Month, Day, Year)  AUG 2 2007   | s Signature                       | de   |  |  |                                 |                                 |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 24 Pay **Physician** 200<del>7</del> 01:50 A Bobbie K. Hawkins /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2X F Months Director 431-54-2511 79 05/07/1928 Arkansas Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 28a-f show aţ 1 ☐ Yes 2 XNo must be notified Director Maryland | Anne Arundel Churchton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6 5520 Carvel Drive 20733 United States or items 23a Funeral 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Completed by 3 Widowed 4 □ Divorced White 'natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the M Cashier Convenience Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Henry Kimbrell Collier Ross ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3625 Conch Drive, Edgewater, Jamie H. Peterson/Son Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Kalas Crematory 07/26/2007 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. 21. Signatur of Funeral Septe Lipepse 2973 Solomons Island Road, Edgewater, Maryland 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, which, or heart failure. List only one cause on each line. Immediate Cause (Final Physician INTRACRANIA DUY 9 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed and Due to (or as a consequence of): burial P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) signed by the a d be detached f 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by HIPELTENSION 2 No 3 ☐ Probably 4 Unknown 1 ☐ Yes peen: 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy performe page After this certificate 2 No 1□ Yes 1 ☐ Yes 2 N/No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient P 2 ER/Outpatient 3 DOA funeral 27. Manne of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide determined the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 7 2007

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 0731 M Walter 25 2007 uly /Medical 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) 4c. County of Death Examiner KENINSULA KEEIGNAL MEDICAL ( Wicomico ENTER PALISBURY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 6. Sex 12 M 2 ☐ F Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours 318-34-9347 Usual Residence of Decedent Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ¥Yes 2 No Director Accomack hincoteague 10e. Street and Number 10g. Citizen of What Country? 23336 USA 5600 Funeral irce 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑No þ 3 ☐ Widowed 4 ☐ Divorced White Completed Department of Heatth and Mental Hygiene, important; If Item 27 is marked other than "natur any Injury or other traumattc event, the Medical Jones. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self nterior Design 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chincoteague VA 233.

Date | 20c. Location - City or Town, State Joshua Jacobson/Frience Willow 23334 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/27/07 Occhannek (Emekr. Jrc.)
22. Name and Address of Facility 4 Donation 5 Dother (Specify) Exmore, VA 21. Signature of Funeral Service Licensee Salyer Funcial Home, Inc. Batt 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1200a /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacoouse contribute to the cause of death? Be Completed by 3 Probably 4 Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Yo 24a. Was an autopsy 1□ Yes 21110 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 L Matural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:..
completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🚅 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title o

30. Name and address of

560 32 Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

|                   |   |                  | 1 _ For  | State of Maryland / Department of Health   |                           | al Hygiene                                | 1117                         | 25235  |
|-------------------|---|------------------|--|--|---------------------------|---|------------------------------|--|
|                   |   |                  | Registrar  | Certificate of Deat  |                           | Reg. No.                                  |                              | To Time ( Doub                                     |
| Н                 | Physicia  |                  | 1. Decedent's Name (First, Middle, Las   | ille Justice   | Mo                        | te of Death<br>onth Day                   | Yeer                         | 3. Time of Death                                   |
|                   | /Medic<br>Examin  |                  | 4a. Fecility Name (If not institution, give  | street and number) 4b. City, Town, or Location   | on of Death               | 4c.                                       | County of Death              | 7  |
|                   |   |                  | Hartley Ho   | 17. Age (In trs. last birthday) If Under 1 Year   If Under   | der 24 Hrs. 8. Dat        | y U                                       | 10rce.                       | ster   |
| П                 | Funeral<br>Director   |                  | 5. Social Security Number 6. Sec. 224–28–5997  | 7. Äge (In frs. last birthday) If Under 1 Year |                           | te of Birth<br>onth, Day, Year)<br>1-27-2 | 9. Birth<br>Cou              | nplace (State or Foreign intry)                    |
|                   | D D   |                  | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or Location  |                           |   |                              | 10d. Inside City Limits                            |
|                   | Maryle<br>fed at  | lor              | ILA Accord   | and Ton it   | 1.                        |   |                              | 1 Tes 2 No   |
|                   | th the<br>or 28a  | lrec             | 10e. Street and Number   | ack remerance und  |                           | 10g. Citi                                 | izen of What Cou             | ıntry?   |
|                   | deeth with the Marylend<br>ims 23a or 28a-f show  | Funeral Director | 11014 San  | dStreet 23442  | 0: 1-0 (04-)              | 10  | 14. Race - Ameri             | January Indian                                     |
| (0                | riter de  | Fune             | 11. Marital Status 1 ☐ Never Married 2 ☐ Married   | 12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 No If Yes, Give  1 □ Yes 2 No Spec  | ican, Puerto Rican,       |   | Black, White                 |  |
| 21215-0036        | be filed within 72 hours after deeth with the Marylen ital Hyglene. Id other than "natural; or items 23a or 28a-f showed other than "natural; or items 23a or 28a-f showed event, it is MacKeal Extinitive round be notified at | d by             | 3 Widowed 4 □ Divorced   | Year or Dates:   | city:                     |   | Specify: 61                  | ack  |
| 15-(              | in 72 h<br>n "natu  | Completed        | 15. Decedent's Ed<br>(Specify only highest grad  | e completed) (Give kind of work done during n  | nost of working           | 16b. Ki                                   | ind of Business/Ir           | ndustry  |
| 212               | ed within<br>giene.<br>er than "  | Com              | Elementary/Secondary (0-12)  | College (1-40r5+) Liven Care to  | Ker                       | Ty  | 150N-                        | toods  |
| and               | ild be filed<br>lental Hygi<br>ked other<br>ic event, I   | Be               | 17. Father's Name (First, Middle, Last)  | 18. Mc   | other's Name (First,      | Middle, Maider                            | Sumame)                      |  |
| Maryland          | should by and Menta marked  | To               | 19a. Informant's Name/Relationship (7  | pe, Print) 19b. Mailing Address (Street and Nur  | mber or Rural Route       | a Number, City o                          | r Town, State, Zi            | ip Code)   |
|                   | od 2<br>lith a<br>27 is<br>r treu   |                  | Perry Justic   | - 50N 201 N. Division  | Street                    | Fruitle                                   | and M                        | d. 21826   |
| Baltimore         | ges 1 and of Head   |                  | 20a. Method of Disposition 1   | 20b. Place of Disposition (Name of cemetery, crematory or other place)   | Date                      | 20c. Lo                                   | ocation - City or T          | own, State   |
| ıltir             | permit. Pages.<br>Department of the<br>Importent: If Ite<br>any injury or of<br>once.   |                  | * 4 □ Donation 5 □ Other (Specify  21. Sign ture I I neral Service                                     | Jerusalen Church Con.<br>22. Name and Address of Fa  | 18-4-0                    | len                                       | perano                       | eville, VA.  |
| B                 | Depared Important in police.  |                  | THE MA   | 911 W. Zrabe   | lla Stre                  | ot. Sal                                   | ichury                       | mel 21801  |
|                   |   |                  | shock, or seart failure. Ust only of   | ications that caused the death. Do not enter the mode of dying, such ne cause on each line.  | as cardiac or respi       | ratory arrest,                            | /                            | Approximate<br>Interval Between<br>Onset and Death |
|                   | Physician<br>/Medical   |                  | Immediate Cause (Final disease or condition resulting in death)  | Ischemic Cardion   | nyopa                     | Thy                                       |                              | 3-44   |
|                   | Examiner  |                  |  | Due to (or as a consequence of):   | ()                        | 0   |                              | 0  |
|                   | , iii   | iner             | Sequentially list conditions, if any, Isating to immediate cause. Enter Underlying                     | Due to for as a sonsequence off:   |                           |   |                              |  |
| ^                 | te be executed<br>ysician and<br>e burial-transit   | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last                                | Due to (or as a consequence of):   |                           |   | -                            |  |
| 1260              | ate be executed hysician and the burial-transit   | cai              |  | 1  |                           |   |                              |  |
| x 68              | death certificat<br>ettending phy<br>d for use as th  | Physician/Med    | IF FEMALE:   | 20 Mars outsons of accessory   |                           |   |                              |  |
| Вох               | death certifica<br>e ettending ph<br>d for use as th  | cian             | 23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \) | 3c. If yes, outcome of pregnancy  1  |                           |   | 23d. Date of deliv<br>Month  | very<br>Day Year                                   |
| P.O.              | 0 0 0   | hysi             | 9 Unknown  | 9□ Unknown   |                           |   |                              |  |
|                   | 26 PB   | by               | Part II. Other significant conditions co   | ntributing to death but not resulting in the underlying cause given in Pa  | art I. 23                 | 3e. Did tobacco u<br>1 ☐ Yes 2 ☑          |                              | the cause of death?                                |
| Records,          | w require<br>been si<br>should b  | ietec            |  |  | 24                        | la. Wasan                                 | 24b. Were aut                | topsy findings available                           |
| Re                | The<br>ite h  | Completed        |  |  | 1                         | autopsy<br>performed?<br>Yes 22 No        | prior to co                  | ompletion of cause of                              |
| Vita              | Physician: Th<br>r this certificate<br>ral director, pag  | Be               | 25. Was case referred to medical examiner?   |  | ace of Death (Chec        |   |                              |  |
| of                | Phys<br>ral di  | : To             | 1 Yes 2 No 27. Manner of Death   | Ospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   28a. Date of Injury (Month, Day Year)   28b. Time of Injury Work?  | Nursing Home 5<br>28d. De | Residence 6                               |                              | (fy)   |
| ion               | utending<br>death.<br>ctor: Afte<br>y the fune  | atior            | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day Year) Injury Work?  M 1 ☐ Yes 2  | . □No                     |   |                              |  |
| Division of Vital | or Attendate death after death  | Certification:   | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                           | cation (Street and<br>ty or Town, State   |                              | ral Route Number,                                  |
|                   | Hospitel or Attending<br>44 hours after death.<br>Funerel Director: After<br>tely filled in by the fune   |                  | 29a. Certifier 12 Certifying Phy   | sician: To the best of my knowledge, death occurred at the time, date  | and place, and due        | e to the cause(s)                         | and manner as                | stated.  |
|                   | To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the  | edical           | (Check only 2 Medical Exem   | ner: On the basis of examination and/or investigation, in my opinion, of and manner stated.  | death occurred at th      | he time, date and                         | place, and due               | to the cause(s)                                    |
| l l               | To t<br>To t  | Σ                | 29b. Signature and title of certifier  | 29c. License number  |                           |   | te signed (Month, $7 - 28$ - |  |
| 1                 | LIND  |                  | 30. Name and address of person who o   |  |                           |   |                              |  |
| 0                 | · V   |                  | SARAD R. BA  | PAI MID , HOUVE MAIKA  | t, St.;                   | MD  | 2185                         |  |
|                   | Sta<br>Registr  | -                | 31. Date filed (Month Gay, Year) 20  | 07 32 Registrar's Signature  |                           |   |                              |  |

| / | 1 | *** | ( | 1  |  |
|---|---|-----|---|----|--|
|   | - |     | 1 | ,) |  |

| 1- | For<br>State<br>Registra |
|----|--------------------------|
|----|--------------------------|

State of Maryland / Department of Health and Mental Hygiene [ ] Certificate of Death

|   |                   | 1. Decedent's Name (First, Middle, Last)   |   |                       |                                       |  | 2. Date of De.<br>Month          | ath<br>Day                            | Year                              | 3. Time of Death                               |
|---|-------------------|--|---|-----------------------|---------------------------------------|--|----------------------------------|---------------------------------------|-----------------------------------|--|
|   | sician<br>edical  | JEWELL WOOD KRAFT  |   |                       |                                       |  | JULY                             | 25                                    | 2007                              | 7:52 AM  |
|   | miner             | 4a. Facility Name (If not institution, give street   | t and number)   |                       | 4b. City, Town,                       | or Location of Death                         |                                  | 4c. C                                 | County of Death                   |  |
|   |                   | HEARTLAND HOUSE  |   |                       | GRASONV                               |  |                                  | QUE                                   | EN ANNE                           |  |
| Fune  |                   | 5. Social Security Number 6. Sex   | 7. Age (In yrs. las   | st birthday)_<br>Yrs. | If Under 1 Year<br>Months Days        |  | 8. Date of Birt<br>(Month, Da    | y, Year)                              | 9. Birthr<br>Cour                 | place (State or Foreign<br>ntry)               |
| Direct  | tor               | Usual Residence of Decedent  | 91  | 113.                  |                                       |  | JANUAKY .                        | ZZ, 19                                | 16 MARY                           | LAND   |
| laryland<br>show  |                   | 10a. State 10b. County   | 10c. City,  | Town or Loc           | ation                                 |  |                                  |                                       | 1                                 | 0d. Inside City Limits                         |
| Mary<br>P-f sh  | ģ                 | MARYLAND QUEEN ANNE  | 'S CHES   | TER                   |                                       |  |                                  |                                       |                                   | 1 Tes 2 No                                     |
| ith the Ma<br>or 28e-f  | Director          | 10e. Street and Number   |   |                       | 10f. Zip Code                         |  |                                  | 10g. Citiz                            | en of What Cour                   | ntry?  |
| ath wit   | <u>a</u>          | 109 HARBOUR SOUND DR   | IVE   |                       | 21619                                 |  |                                  | UNIT                                  | ED STAT                           | ES   |
| ter dea   | Funeral           |  | Vas Decedent Ever in U.S.<br>Armed Forces?  |                       | as Decedent of I<br>Yes, specify Cub  | Hispanic Origin? (Sp<br>pan, Mexican, Puerto | pecify Yes or No<br>Rican, etc.) | - 1                                   | 4. Race - Americ<br>Black, White, |  |
| ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Hoelith and Mental Hygiene. Item 21 is marked other than "natural; or Items 23s or 28e-f show other treumstic event; the Medical Exercise master profiled at | 호<br>고            | 3 Widowed 4 □ Divorced   | ☐ Yes 2 <b>T</b> No<br>1 Yes, Give<br>rear or Dates:  | 1                     | □Yes 2MINo                            | Specify:                                     |                                  | 5                                     | Specify: WH]                      |  |
| 5-0<br>72 hc  | Completed         | 15. Decedent's Education (Specify only highest grade control of the control of th | n<br>npleted)   | (Give k               | ent's Usual Occu<br>ind of work done  | durina most of worl                          | king                             | 16b. Kin                              | d of Business/In                  | dustry   |
| Mithin Man  | ğ                 | Elementary/Secondary (0-12)  | College (1-4or 5+)  |                       | O NOT use retire                      | ed)  |                                  |                                       |                                   |  |
| d 21<br>filed w<br>Hygier<br>stherti  | ខឹ                | 17. Father's Name (First, Middle, Last)  | 4+  | NURSIN                | (G                                    | 18. Mother's Nam                             | o /First Middle                  |                                       | THCARE                            |  |
| Maryland 2121 d 2 should be filed within the and Mental Hygiene. R7 is marked other than treumatic event, if e.m.   | Be                |  |   |                       |                                       |  |                                  |                                       |                                   |  |
| should and Men marke  | ၉                 | PERCY LEE WOOD  19a. Informant's Name/Relationship (Type, I  | Print)  | 10h Mailing           | Address /Street                       | CATHERIN<br>t and Number or Ru               |                                  |                                       |                                   | Codel  |
| Ma<br>d 2 s<br>d 2 s<br>th an<br>7 is r   | 710               | KATHERINE GARRINGER-   | - was well as the   |                       |                                       |  |                                  |                                       |                                   |  |
| Baltimore, M permit. Pages 1 and 2 Depertment of Heelth Important: If Item 27.  |                   | 20a. Method of Disposition   | 20b. Pla  | ce of Dispos          | tion (Name of                         |  | Date CH                          |                                       | ation - City or To                |  |
|   |                   | 1 ☐ Burial 2 🛣 Cremation 3 ☐ Remo  | vai from State  | •                     | atory or other pla                    | ice)   | 26,200                           |                                       |                                   |  |
| Baltimo<br>permit. Page<br>Depertment of<br>Important: If   |                   | 21. Signature of Fuperal Service Licensee  | CHES  |                       | Name and Addr                         | LON SECULIA                                  |                                  | STEV                                  | ENSVILL                           | E, MARYLAN                                     |
| Ba<br>Perm<br>Deperment   | once              | M  | 4100  | FEI                   | LOWS, H                               | ELFENBEIN<br>CK ROAD,                        | AND NE                           | WNAM                                  | FUNERAL                           | HOME, P.A                                      |
| Physicia<br>/Medic<br>Examin  | al                | shock, or heart failure. List only one ca<br>tmmediate Cause (Final<br>disease or condition<br>resulting in death)   | CANCER OF BR  |                       | VITH MET                              | ASTASIS                                      |                                  |                                       |                                   | Interval Between<br>Onset and Death            |
| cuted   | Examiner          | Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events  | Due to for as a conseque  | atica of).            |                                       |  |                                  |                                       |                                   |  |
| Box 68760, eath certificate be executed attending physicien and for use as the burial-transit   |                   | resulting in death) Last   | Due to (or as a conseque  | ance of):             |                                       |  |                                  |                                       |                                   | The second                                     |
| C 68  | Med               | IF FEMALE:   |   |                       |                                       |  |                                  |                                       |                                   |  |
|   | Physician/Medical | 23b. Was decedent pregnant in the past 12 months?  | f yes, outcome of pregnand<br>I □Live birth 2 □ Fetal d<br>I □ Pregnant at time of dea<br>I □ Unknown | death 3 □E            | Ectopic pregnanc<br>Other (specify) _ | ey .   |                                  | 23                                    | 3d. Date of delive<br>Month       | ery<br>Day Year                                |
| by P.O. s that the de ned by the a detached   | 4 V               | Part II. Other significant conditions contribu   | iting to death but not result   | ting in the und       | derlying cause gr                     | ven in Part I.                               | 23e. Did t                       | obacco us                             | e contribute to t                 | ne cause of death?                             |
| rds,  | D<br>D            | CORONARY ARTERY DIS  | EASE  |                       |                                       |  | 10,                              | res 2□                                | No 3□Prot                         | ably 4X Unknown                                |
| of Vital Records, P.O. Physician: The law requires that the d rubs certificate has been signed by the ral director, page 2 should be detached.  | Completed by      | DIABETES   |   |                       |                                       |  | 24a. Was<br>autop<br>perfo       |                                       | prior to co<br>death?             | psy findings available<br>mpletion of cause of |
| tat<br>In: T<br>ifficete  | ပိ                | 25. Was case referred to medical   |   |                       |                                       | 06 Dia 4 Di                                  | 1 ☐ Yes                          | 2 <b>X</b> No                         | 1 🗆 Yes                           | 2∐ No  |
| of Vita Physician: this certific  | B                 | examiner?  1 Yes 2 No  | ital:<br>1 ☐ Inpatient 2 ☐ El   | P/Outpatient          | 3□ DOA Ot                             | 26. Place of Dea                             |                                  |                                       | Viother (Case)                    | ASSISTED LI                                    |
| Phy<br>Praid<br>Braid   | 5.                | The state of the s |   | 28b. Time of          | 28c. Inju                             |  | 28d. Describe I                  |                                       |                                   | APOIDIED III                                   |
| Division or Attending after death. Director: After  | cation            | 2 Accident investigation   |   | Injury                | M 1                                   | ]Yes 2 □No                                   | 20( ) /                          | · · · · · · · · · · · · · · · · · · · |                                   | 10   |
| Division tel or Attenders after death al Director:  | Certification:    | 4 Homicide determined 2  | Be. Place of Injury - At hom building, etc. (Specify)   | ie, iarm, stre        | et, ractory, office                   |  | City or Tou                      | vn, State)                            | ivumber or Hura                   | al Route Number,                               |
| Division or<br>To the Hospitel or Attending Phywithin 24 hours after death.<br>To the Funeral Director: After the   | Medical           | (Check only 2 Medical Examiner:  | n: To the best of my knowl<br>On the basis of examinationand manner stated.                           |                       |                                       |  |                                  |                                       |                                   |  |
| Vithin 2<br>To the  | Me                | 29b. Signature and title of certifier  | 00  | )                     | 29c. Licen                            | se number                                    |                                  | ∠9d. Date                             | signed (Month,                    | Day, Year)                                     |
| 10  |                   | Jell N, W  | lklisur   |                       | Doc                                   | 2706   | 55                               | 7/2                                   | 5/01                              |  |

State Registrar JOEL H. WILKERSON, M.D. 204 MEDICAL CENTER ROAD, GRASONVILLE, MARYLAND 21638
31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 9:43 PM Richard Eugene KEYSER, Sr. August 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 XM 2 □ F 76 207-22-1967 Oct.24,1930 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show a or 28a-f sh 1 □Yes 2 No Director Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 11009 Larch Avenue 21740 USA "natural", or items 23a Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ribbon manufacturer plant manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Oscar Keyser Elizabeth Saville Robinson ၉ Department of Health and Men Important: If item 27 Is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Keyser - wife 11009 Larch Ave., Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 😾 Burial 2 □ Cremation 3 □ Removal from State 8/7/09 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park Hagerstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740 23a. Fart1. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alioblash me Mi / Diforme /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specity) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2□ No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA r 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After 1 Natural 5 Pending investigation M 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a

To the Funeral [ 29a. Certifier (Check only 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 041667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nedical Compos the jewstown mo 15H-5+1 Michael neck 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

|                            |  |   | 1 - For<br>State<br>Registrar  |  | -  | Department of F<br>Certificate of I  |   | Reg.  | Ella CO TOTAL B  | 20200  |
|----------------------------|--|---|--|--|--|--|---|---|--|--|
|                            |  |   | Decedent's Name (First, Middle,)   | Last)  | _  |  |   | 2. Date of Death  |  | 3. Time of Death   |
|                            | Physicia   |   | Nagarattir   | nam C.   | Kath   | irgamathamb  | У   | Month July 20.  | Day Year 2007  | 1430 P M   |
|                            | /Medic<br>Examin   |   | 4a. Facility Name (If not institution,   | give street and number)  |  | 4b. City, Town, o  | r Location of Death   |   | 4c. County of Dea  |  |
|                            |  |   | Allegany Co. Nur   | sing & Reha  | b. Ctr.  |  | berland   |   |  | legany   |
|                            | Funeral  |   |  |  | (In yrs. last birt   |  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Ye   | ar) 9. Biri  | thplace (State or Foreign ountry)  |
|                            | Director   |   | 214-88-5188 Usual Residence of Decedent  | 1□M 2XF   8  | 9  | Yrs.   |   | 12/12/19  | 7 Sri  | Lanka  |
|                            | land ow  |   | 10a. State 10b. County   |  | 10c. City, Town  | or Location  |   |   |  | 10d. Inside City Limits  |
|                            | Mary<br>1 sh   | tor   | MD All   | egany  |  | LaVale   |   |   |  | 1 ☐ Yes 2 📉 No   |
|                            | r 28a  | Director  | 10e. Street and Number   |  |  | 10f. Zip Code  |   | 10g.  | Citizen of What Co   | ountry?  |
|                            | within 72 hours after death with the Maryland<br>ene.<br>then "naturel", or items 23e or 28a-f show<br>the Medical Examinar must be notified at  | al D  | 906 Weires Ave   | nue  |  | 2  | 1502  |   | Sri  | Lanka  |
|                            | ems :  | Funeral   | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?  | ver in U.S.  | 13. Was Decedent of H<br>If Yes, specify Cuba  | lispanic Origin? (Spean, Mexican, Puerto                                    | cify Yes or No-<br>Rican, etc.)   | 14. Race - Ame<br>Black, Whit  |  |
| 9                          | s after  | by Fu   | 1 Never Married 2 Married  | 1 ☐ Yes 2 ☑ N  | lo   | 1 ☐ Yes 2 ☑ No   | Specify:  |   | Specify:   |  |
| 2-003p                     | hours<br>turel   | q pa  | 3 ¼ Widowed 4 ☐ Divorced  15. Decedent's   | Year or Dates:   | 162  | Decedent's Usual Occup   | ation   | 16h   | Kind of Business   | Asian  |
| Ċ                          | in 72<br>in na   | ojet  | (Specify only highest  | grade completed)   |  | (Give kind of work done life. DO NOT use retired   | during most of worki  | ng  | Taria di Badinoda  | ······································   |
| 7                          | with<br>jiene.<br>r the  | Completed   | Elementary/Secondary (0-12)  | College (1-4or 5   | +)   | Homema   | aker  |   | Home   |  |
| ana                        | e filec<br>ti Hyg<br>othe<br>vent,   | Bec   | 17. Father's Name (First, Middle, La   | st)  |  |  | 18. Mother's Name   | (First, Middle, Maid  | len Sumame)  |  |
| <u>a</u>                   | uld by<br>Menta<br>Virked<br>vrice   | To E  | Chellapah  | Kan  | napathip   | illai  | Theivan   | ai  | Kathir   | abelpillai   |
| Mar                        | 2 sho<br>and I<br>is ms  |   | 19a. Informant's Name/Relationship   |  |  | Mailing Address (Street  |   |   | •  |  |
| e)<br>S                    | and<br>ealth<br>m 27<br>her tr   |   | Vimala A. Ranjit   | han /daught  |  | 06 Weires A  |   |   |  | 1502   |
| 0                          | ges 1<br>it of H<br>if ite<br>or otl   |   | 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3  |  |  | Disposition (Name of<br>y, crematory or other place  |   |   | Location - City or   |  |
| altimor                    | t. Pa<br>rtmen<br>rtent:<br>rjury  |   | ' 4 □ Donation 5 □ Other (Special Service Line)  |  | Cumbe  | rland Crema  |   |   |  | L Home, P.A.   |
| g                          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23e or 28a4 show any injury or other treumetic event, the Medical Examinat must be notified at once.                                      |   | 21. Signature Fruit rai Service Lin  | Call Call  |  | 404 Decat  |   |   |  | 21502  |
|                            | MICH   | _   | 23a. Part1. Enter the disease, or co   | omplications that caused   | the death. Do n  |  |   |   | <u> </u>   | Approximate  |
|                            | Physician  |   | shock, or heart failure. List or<br>Immediate Cause (Final   |  |  |  |   |   |  | Interval Between<br>Onset and Death  |
|                            | rilysiciali  |   | disease or condition   |  |  |  | 1 1 C N 1   | 3 1 1 1 1 1   | - K  | ~~ U/) /   |
|                            | /Medical   |   | resulting in death)  | Due to (or as a  | a consequence of   | ALZHEIM  | (EILS DI  | BUSUT   | ( <del>k</del>   | TYP  |
|                            | /Medical<br>Examiner   |   |  | a. Due to (or as a   | a consequence of   | ALZHE (M   | (EILS D)  | EMENT   | ( <del>k</del>   | 7 1/21   |
| ì                          | Examiner   | iner  | Sequentially list conditions,  | Due to (or as a  | a consequence of   | of):   | (EICS DI  | ENEUT   | <del></del>  | TYP  |
|                            | Examiner   | caminer   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | b  | a consequence of   | of):   | (6/45 0)  | BNEUT   | ( <del>K.</del>  | 7 424  |
| ,00                        | Examiner   | al Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | b  | a consequence o  | of):   | (6/25 0)  | BUBUT   | ( <del>K</del>   | TYPI   |
| 08/00,                     | Examiner   | edical Examiner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | b  | a consequence of   | of):   | (6/25 0)  | EMENT   | ( <del>K</del> -   | 7 422  |
| _                          | ficate be executed mines of physician and state burial-transit and   | edical  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | Due to (or as a c  | a consequence of a consequence of pregnancy  | of):   |   | BUSUT   | 23d. Date of de  |  |
| . Box 68/60,               | ficate be executed mines of physician and state burial-transit and   | edical  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   | Due to (or as a b  | a consequence of a consequence of pregnancy  | of):   |   | BUSUT   |  |  |
| O. Box                     | ficate be executed mines of physician and state burial-transit and   | edical  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant  | Due to (or as a b.  Due to (or as a c.  Due to (or as a d.  23c. If yes, outcome 1 \( \bullet \) Live birth  | a consequence of a consequence of pregnancy  | of):  of):  3 □Ectopic pregnancy   |   |   | 23d. Date of de<br>Month   | livery<br>Day Year   |
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| P.O. Box                   | The law requires that the death certificate be executed to ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | Physician/Medical   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  | Due to (or as a  b   | a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death   | of):  of):  3 □Ectopic pregnancy 5 □ Other (specify) □   | ,   | 23e. Did tobacc 1  Yes 24a. Was an  | 23d. Date of de Month  o use contribute to 2 PNo 3 Pour Prior to 2 Prior to 2 death?   | livery Day Year  o the cause of death? robably 4 □Unknown  |
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| Vital Records, P.O. Box    | The law requires that the death certificate be executed to ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | To Be Completed by Physician/Medical                        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or as | a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death at not resulting in   | of):  3   Ectopic pregnancy 5   Other (specify)    the underlying cause give   | en in Part I.  26. Place of Deather: 4 ⊋Nursing Hoi                         | 23e. Did tobacc  1  Yes  24a. Was an autopsy performed 1  Yes 2  (Check only one)  me 5  Residence  | 23d. Date of de Month  o use contribute to 2 PNo 3 Prior to death? 1 Yes 6 Other (Spe  | livery Day Year  o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of  |
| or Vital Records, P.O. Box | The law requires that the death certificate be executed to ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | To Be Completed by Physician/Medical                        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or as | a consequence of pregnancy 2 Fetal death time of death at not resulting in the consequence of the consequence of pregnancy 2 Fetal death time of death at not resulting in the consequence of th | af):  af): af):  | en in Part I.  26. Place of Deather: 4 ⊋Nursing Hoi                         | 23e. Did tobacc  1  Yes  24a. Was an autopsy performed 1  Yes 2  A  | 23d. Date of de Month  o use contribute to 2 PNo 3 Prior to death? 1 Yes 6 Other (Spe  | livery Day Year  o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of  |
| or Vital Records, P.O. Box | The law requires that the death certificate be executed to ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | To Be Completed by Physician/Medical                        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or as a b. Due to (or as a c. Due to (or as a d. Due birth 4 Pregnant at 9 Unknown s contributing to death but be death but 1 Department of the death but  | a consequence of a consequence of a consequence of a consequence of pregnancy 2 Fetal death time of death at not resulting in the consequence of the consequence of pregnancy 2 Fetal death time of death at not resulting in the consequence of  | af):  af): af):  | en in Part I.  26. Place of Death len: 4. Aursing Holy y at k? Yes: 2. □ No | 23e. Did tobacc  1  Yes  24a. Was an autopsy performed 1 Yes 2  (Check only one)  me 5  Residence 28d. Describe how in 28f. Location (Street  | 23d. Date of de Month  o use contribute to 2 PNo 3 Prior to death? 1 Yes 6 Other (Spenjury occurred  | livery Day Year  o the cause of death? robably 4 □Unknown utopsy findings available completion of cause of s 2 □ No  |
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| or Vital Records, P.O. Box | The law requires that the death certificate be executed to ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | Certification: To Be Completed by Physician/Medical         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  25. Was case referred to medical examiner? 1   Yes 2   No   27. Manner of Death 1   Natural   5   Pending   Pendi | Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or as | a consequence of pregnancy 2   Fetal death time of death at not resulting in the consequence of the consequence of pregnancy 2   Fetal death time of death at not resulting in the consequence of the consequence of pregnancy 2   ER/Out y   28b. Telephone of the consequence of the conseque | af):  af): af):  | 26. Place of Death ler: 4 ☑ Nursing Hor y at k? Yes 2 □ No                  | 23e. Did tobacc  1  Yes  24a. Was an autopsy performed 1 Yes 2  A (Check only one)  me 5  Residence 28d. Describe how in City or Town, Si and due to the cause  | 23d. Date of de Month  o use contribute to 2 PNo 3 Pri 24b. Were an prior to death? 1 Yes 6 Other (Spenjury occurred  and Number or Rate)  | o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of s 2 No  pointy)  ural Route Number,  s stated.  |
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| or Vital Records, P.O. Box | To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit   | Certification: To Be Completed by Physician/Medical         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 mgaths? 1   | Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or as | a consequence of pregnancy 2 Fetal death time of death at not resulting in the consequence of the | af):  af): af):  | 26. Place of Death ler: 4  Nursing Holy y at k? Yes 2  No                   | 23e. Did tobacc  1  Yes  24a. Was an autopsy performed 1  Yes 2  Ar (Check only one)  me 5  Residence 28d. Describe how in 28f. Location (Street City or Town, Stand due to the cause ed at the time, date                        | 23d. Date of de Month  o use contribute to 2 PNo 3 Pri 24b. Were an prior to death? 1 Yes 6 Other (Spenjury occurred  and Number or Rate)  | livery Day Year  o the cause of death? robably 4 Unknown utopsy findings available completion of cause of s 2 No  acity)  ural Route Number, s stated. e to the cause(s)                     |
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| or Vital Records, P.O. Box | To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit   | Medical Certification: To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or as | a consequence of pregnancy 2 Fetal death time of death at not resulting in the consequence of pregnancy 2 Fetal death at not resulting in the consequence of pregnancy 2 Fetal death at not resulting in the consequence of pregnancy 2 Fetal death at not resulting in the consequence of pregnancy 2 Fetal death at not resulting in the consequence of the consequence o | and the underlying cause gives the underlying ca | 26. Place of Deather: 4 Nursing Hory at k? Yes 2 \ No                       | 23e. Did tobacc  1  Yes  24a. Was an autopsy performed 1 Yes 2    1  Yes 2    1  Yes 2    28d. Check only one)  me 5  Residence 28d. Describe how in 28f. Location (Street City or Town, Stand due to the cause at the time, date | 23d. Date of de Month  to use contribute to 2 PNo 3 PNO 1 PN | ilivery Day Year  o the cause of death?  robably 4 Unknown  utopsy findings available completion of cause of s 2 No  ocify)  ural Route Number,  s stated. s to the cause(s)  th, Day, Year) |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                     |   |  | For<br>State<br>Registrar   | State of Marylar   |                        | tificate of                                     |   | ,                               | Reg. No                | 1 57 /3 77                                       | 8100                   | 1. 3     |  |
|---------------------|---|--|---|--|------------------------|---|---|---------------------------------|------------------------|--|------------------------|----------|--|
|                     | Physicia  |  | 1. Decedent's Name (First, Middle, Last   | ,  |                        |   |   | 2. Date of Dea                  | Day                    | Year   | 3. Time of E           |          |  |
|                     | /Medic  | al   | MARY  | RUTH   |                        |   | OTZ<br>Location of Death                    | 07                              | 24                     | 07<br>County of Death                            | 1830                   | M        |  |
|                     | Examin  | er   | 4a. Facility Name (If not institution, give WMHS-BRADDOCK CAM   |  |                        | CUMBERI   |   |                                 |                        | LEGANY   | I                      |          |  |
|                     | Funeral   |  | Social Security Number 6. S | 7. Age (In yrs   | last birthday)         | If Under 1 Year Months Days                     | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birt<br>(Month, Da   | h                      | 9. Birth   | place (State or intry) | Foreign  |  |
|                     | Director  |  | 219-10-1445   | □M 2\PF 84   | Yrs.                   | World Days                                      | Hours Will.                                 | 08/03/                          |                        |  | nsylvan:               | ia       |  |
|                     | and<br>w  |  | Usual Residence of Decedent  10a. State 10b. County   | 10c. C   | ty, Town or Lo         | cation  |   |                                 |                        |  | 10d. Inside City       | / Limits |  |
|                     | Maryl<br>-f sho<br>ied a  | ţo   | MD Garre  | ett  |                        | Grantsvil                                       | Lle   |                                 |                        |  | 1 TYes                 | 2 💢 No   |  |
|                     | h the<br>or 28a<br>s notii  | irec   | 10e. Street and Number  |  |                        | 10f. Zip Code                                   |   |                                 | 10g. Citiz             | en of What Cou                                   | intry?                 |          |  |
|                     | 23a c<br>ust b  | Funeral Director   | 891 Dorsey Hot  |  |                        |   | 1536  |                                 |                        | USA  |                        |          |  |
|                     | er de@<br>items<br>ner m  | nue  | 11. Marital Status 1 ☐ Never Married 2 ☐ Married  | 12. Was Decedent Ever in L<br>Armed Forces?  | J.S. 13.               | Was Decedent of H<br>If Yes, specify Cub        | lispanic Origin? (Sp<br>an, Mexican, Puerto | ecify Yes or No<br>Rican, etc.) | - 1                    | <ol> <li>Race - Amer<br/>Black, White</li> </ol> |                        |          |  |
| 36                  | urs aft<br>al", or<br>xami  | by F   | 3 ☐ Widowed 4 💆 Divorced  | 1 ☐ Yes 2 ☐ No<br>if Yes, Give<br>Year or Dates:                                     |                        | 1∐Yes 2∏(No                                     | Specify:                                    |                                 |                        | Specify:<br>Wh                                   | ite                    |          |  |
| 200                 | 72 hours after death with the Maryland<br>'natural', or items 23a or 28a-f show<br>dical Examiner must be notified at | sted   | 15. Decedent's Edi<br>(Specify only highest grad  | ucation<br>de completed)   | (Give                  | dent's Usual Occup                              | durina most of work                         | (ina                            | 16b. Kin               | o. Kind of Business/Industry                     |                        |          |  |
| 21                  | within ene  | Completed  | Elementary/Secondary (0-12)   | College (1-4or 5+)   | life.                  | <i>DO NOT use retire</i><br>ore Manag           | d) -  |                                 |                        | Retail   |                        |          |  |
| 2                   | be filed<br>ttal Hygi<br>d other<br>event, t  | ပ္ပိ   | 17. Father's Name (First, Middle, Last)   |  | ] 50.                  | or o mamae                                      | 18. Mother's Nam                            | e (First, Middle,               |                        |  |                        |          |  |
| au                  |   | To Be  | Allen   | Com  | pton                   |   | Ruth  | I                               | lnna                   | E  | Bowman                 |          |  |
| Maryland 21215-0036 | 2 should b<br>and Ment<br>is marked<br>aumatic e  |  | 19a. Informant's Name/Relationship (7   | ype. Print)  | 19b. Mailir            | ng Address (Street                              | and Number or Ru                            | ral Route Numb                  | er, City or            | Town, State, Z                                   | ip Code)               |          |  |
|                     | # A B G   |  | S. Elizabeth Nicho  |  |                        |   | Street, 1                                   | <del></del>                     |                        |  |                        |          |  |
| lore                | Page<br>nent o<br>int: If<br>iry or   |  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐   | Hemovai from State   |                        | sition (Name of<br>matory or other pla          |   | Date                            |                        | cation - City or                                 |                        |          |  |
| Baltimore,          |   |  | 4 □ Donation 5 □ Other (Specify 21. Signatu of uneral Service Licen   | 1 - 4.   |                        | nd Cremat<br>2. Name and Addre                  | ory 07/2                                    | 25/2007 <br>dams Fan            |                        |  |                        | DΛ       |  |
| Ba                  | permit. Departr Importa any Inju  |  | 11406   | 12 M   |                        |   |   |                                 |                        |  | 21502                  | 1 • A •  |  |
| Г                   | - 6   | 23a. Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. |   |  |                        |   |   |                                 |                        |  |                        |          |  |
|                     | Physician   | 8 0  | Immediate Cause (Final disease or condition   | . SEPTIC   |                        |   |   |                                 | Onset and D            | eath   |                        |          |  |
|                     | /Medical<br>Examiner  |  | resulting in death)  Duy to (or as a consequence of):  ATRIAL FIBRILLATION  |  |                        |   |   |                                 |                        |  |                        |          |  |
| 3                   |   | er   | Sequentially list conditions, if any, leading to immediate  | b. Due to (or as a co. se  | quence of):            | SPOILLI   | () ( 0) (                                   |                                 |                        |  | 10012                  |          |  |
|                     | cuted   | Examiner   | if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Renal  | tail                   | tajlure   |   |                                 |                        |  | IWK                    | _        |  |
| 90,                 | ifficate be executed<br>g physician and<br>as the burial-transit  | Ex   | resulting in death) Last  | Due to (or as a conse  | quence of):            | CALLA   | RE  |                                 |                        |  | Luk                    |          |  |
| 68760,              | icate b<br>physic<br>the b  | edical   | d. Respiratory Pricare  |  |                        |   |   |                                 |                        |  |                        |          |  |
|                     | # Do Si   |  | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome pf pregr  |                        |   |   |                                 | 2                      | 3d. Date of deli                                 | very                   |          |  |
| Box                 | death<br>e atter  | Physician/M  | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 1 ☐ Live birth 2 ☐ Fe<br>4 ☐ Pregnant at time of<br>9 ☐ Unknown                      |                        | ⊒Ectopic pregnanc<br>⊒ Other <i>(specify)</i> _ | у   |                                 |                        | Month  | Day Y                  | ear      |  |
| P.0                 | s that the de<br>ned by the a<br>detached   | Phys   | 9 ☐ Unknown  Part II. Other significant conditions or   |  | aultina in the u       | adadiána ooyon ah                               | en in Dort i                                | 230 Did t                       | obagos us              | so contributo to                                 | the cause of de        | nath?    |  |
|                     | ii En S   | by   | CHoleust  |  | sulling in the d       | ridenying cause gi                              | ellili Falti.                               |                                 |                        |  | obably 4               |          |  |
| COL                 | w require<br>been sign  | letec  |   |  |                        |   |   | 24a. Was                        | an                     | 24b. Were au                                     | topsy findings a       | vailable |  |
| or Vital Records,   | has<br>has  | Completed  |   |  |                        |   |   | auto<br>perfo<br>1□ Yes         | psy<br>ormed?<br>2. No | prior to death?<br>1 ☐ Yes                       | completion of ca       | use of   |  |
| ital                |   | 0  | 25. Was case referred to medical examiner?  |  |                        |   | 26. Place of Dea                            |                                 |                        | 10163  | 2,23410                |          |  |
| <u> </u>            | ys<br>dir   | To B   | 1 Yes 2 No  |  | ER/Outpatie            |   | 4 □ Nursing H                               | ome 5 ☐ Resi                    |                        |  | cify)                  |          |  |
| N C                 | ling<br>After<br>fune   | ion:   | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation   | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury | Wo  | ryat<br>rk?<br>∣Yes 2 ∐ No                  | 28d. Describe                   | how injury             | occurred   |                        |          |  |
| Division            | Attending r death. ector: After by the fune   | ficat  | 3 Suicide 6 Could not be  | 28e. Place of injury - At I  | nome, farm, st         |   |   | 28f. Location (                 | Street and             | d Number or Ru                                   | ıral Route Numi        | ber,     |  |
| ò                   | s after<br>s after<br>al Dire   | Certification:   | 4 ☐ Homicide determined   | building, etc. (Spec   | any)                   |   |   | City or To                      | wn, State)             | <u>'</u>   |                        |          |  |
|                     | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the            | Medical  |   | ysician: To the best of my kr<br>niner: On the basis of examin<br>and manner stated. |                        |   |   |                                 |                        |  |                        | )        |  |
|                     | To the within 2 To the comple   | Me   | 29b. Signature and title of certifier   | A 1  |                        | 29c. Licens                                     | se number                                   |                                 | 29d. Date              | e signed (Monti                                  | h, Day, Year)          |          |  |
|                     |   |  | Subuhert  | Namals/  |                        | D5  | 18655                                       |                                 | 7                      | 125/07.  |                        |          |  |
|                     | nes   |  | 30. Name and address of person who  | Nawab F  | em 23a) (Type,         | Print)<br>1x 265                                | Grantsi                                     | rille, A                        | ND                     | 2153   | 6                      |          |  |
|                     | Sta<br>Regist   |  | 31. Date filed (Month, Day, Year)  JUL 2 5 200  | 32 Registrar's Sigi  | nature                 | arts)   |   |                                 |                        |  |                        |          |  |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 1700 M John Godfrey Lofgren /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEDICAL CENTER Micamica CLENAL ALISBURY ENINSULA If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours **1** M 2 □ F 181-12-6089 Yrs. 87 Director Dec. 11, 1919 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show notified at 1 XYes 2 No Director Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or other traumatic event, the Medical Examiner must be 8736 Bi-State Blvd. 21875 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Nayes 2 No 1942− f Yes, Give rear or Dates: 1945 1 Never Married 2 Married 'natural", or Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) State Police Maintenance permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If Item 27 is marked other: any Injury or other traumatic event. \*\* 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Swann Lofgren Olivia Pauline Westman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie Joan Lofgren (wife) 8736 Bi-State Blvd. Delmar, MD 21875 20b. Place of Disposition (Name of cemetery, crematory or other place)
Eastern Shore
Veterans Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) eterans Cemetery Aug. 3, 2007 Hurlock, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Short Funeral Home 13 E. Grove Street 19940 Delmar, DE prisations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death the Immediate Cause (Final **Physician** SCVD disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner as the bunal-tran and Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ۵ 2 No 3 Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 2 No certificate 2□No 1∐ Yes 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 1/2001

M

29b. Signature and title of certifier

ress of person who completed cause of death (Item 23a) (Type, Print)

legistrar's Signature

Siva Kumar

Year)

29c. License number

29d. Date signed (Month, Day, Year)

07-05767 Nicholas Lutzio

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007-26242

|  |                  | 1- For State<br>Registrar                                       |                               |                                       | Cert          | tificate o                   | f Death                      |          |             |           | R                                       | eg. No                 | . 01                            |                | en q                                      |
|--|------------------|---|-------------------------------|---------------------------------------|---------------|------------------------------|------------------------------|----------|-------------|-----------|---|------------------------|---------------------------------|----------------|---|
| Physicia   |                  | Oecedent's Name (First, Midd                                    | le,Last)                      |                                       |               |                              |                              |          |             | - 2       | 2. Oate of Dea                          | Death 3. Time of Death |                                 |                |   |
| ledical Exami  | ner              | Nicholas Jose   | ph Lutz                       | cio, J                                | r.            |                              |                              |          |             |           | July 27, 2                              | 007                    | rear                            |                | 1415 hrs                                  |
|  |                  | 4a. Facility Name (if not institution 13112 Two Farm Roa        |                               | and number)                           |               |                              | 4b. City, Tow<br>Silver S    |          | cation of   | Oeath     |   |                        | 4c. County of Death  Montgomery |                |   |
| Funeral  | _                | 5. Social Security Number                                       | 6. Sex                        | 7. Ag                                 | e (In yrs. la | st birthday)                 | If Under 1                   | Year     | If Under    | 24Hrs.    | 8. Oate of Bi                           | rth (MN                | //Do/YYYY)                      | 9. Birth       | nplace (State or                          |
| Director   |                  | 187-32-0652   | 1X M 2                        | F (                                   | 65            | Yrs                          |                              | Oays     | Hours       | Min.      | March                                   |                        | 1                               | Foreigr<br>Cou | Pennsylvani                               |
| апу  |                  | Usual Residence of Oecedent  10a. State 10b. County             |                               |                                       | 10c City      | Town or Locat                | ion                          |          |             |           |   |                        |                                 |                | 10d. Inside City Limits                   |
| <b>*</b> .   | or               | Maryland Anne   |                               |                                       |               | Annapo                       |                              |          |             |           |   |                        |                                 |                | 1 Yes 2 X No                              |
| with the Maryland<br>is 23a or 28a-f she<br>e notified at once   | Direct           | 10e. Street and Number 601 Lighthouse                           | Landir                        | ng Lane                               | e             |                              | 10f. Zip ∞ 21409             |          |             |           |   | 10g. Ci                | itizen of Wha<br>USA            |                | try?                                      |
|  | Funeral Director | 11. Marital Status 1 Never Married 2 X N                        | larried Ar                    | as Oecedent<br>med Forces?<br>Yes 2   | No            | If Y                         | es, specify C                | uban, N  | Mexican,    |           | cify Yes or No<br>Rican, etc.)          | 0-                     | . White,                        | etc.           | an Indian, Black,                         |
| s afte   | by               | Widowed 4 Oi  15. Decedent's Education (Spe                     | vorced If Yes, C              |                                       |               | 16a. Deceder                 | Yes 2 X                      |          |             | ind of we | ork dana                                | 116h                   | Specify:<br>Kind of Bus         |                |   |
| y, MD 21215-0036 and 2 should be filed within 72 hours after death teath and Mental Hygene. tean 21 is marked other than "matural", or iten traumatic event, the Medical Examiner must.  | ompleted         | Elementary/Secondary (0-12)                                     |                               | lege (1-4 or                          |               | during m                     | ost of working               |          |             |           |   |                        |                                 |                | vement                                    |
| 5-0036<br>led within 72<br>Hygiene.<br>other than the Medical  | mo:              | 17. Father's Name (First, Middle                                | Last)                         |                                       | L             |                              |                              | 18       | .Mother's   | Name (    | First, Middle,                          | Maide                  | n Surname)                      |                |   |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than   | Be C             | Nicholas J  |                               | utzio                                 | Sr.           | * * * * *                    |                              |          |             |           | orothy                                  |                        |                                 | 1a             |   |
| 212<br>buld b<br>I Men<br>mar  | To E             | 19a. Informant's Name/Relation                                  |                               |                                       | ,             |                              | g Address (                  | Street a |             |           | ural Route Nu                           |                        |                                 |                | Zip Code)                                 |
| MD<br>d 2 sho<br>1th and<br>n 27 is  |                  | Mary Frances L  | utzio/                        | Wife                                  |               |                              |                              |          |             | nding     |   | Anı                    | napoli                          | s, l           | MD 21409                                  |
| re,<br>s l and<br>f Heal<br>ff iten<br>er tra  |                  | 20a. Method of Oisposition  1 X Burial 2 Crematic               | n 3 Pen                       | noval from St                         |               | lace of Oispor               | her place)                   |          |             |           | Oate                                    |                        | . Location -                    | •              |   |
| Baltimore, MD 21215-0036 Departit Pages and 2 should be filed within 72 Department of Health and Mental Hygiers In Inportant: If tiem 27 is marked other than Injury or other traumatic event, the Medical   |                  | 4 Oonation 5 Other S  |                               | iovai nom on                          |               | emont                        | Cemete                       | ry       |             | 8/1/      | 07                                      | Da                     | vidso                           | nvi1           | lle, MD<br>al Home                        |
| Salti<br>rmit.<br>eparto<br>nport<br>jury  |                  | 21. Signature of Funeral Service                                | Licensee                      |                                       | •             | 22.1                         | Name and Ad                  | dress o  | f Facility  | Geo       | rge P.                                  | Ka:                    | las Fu                          | ner            | al Home                                   |
| m 89 = €   |                  | 100000000   |                               |                                       |               | 29                           | 973 Sol                      | Lomo     | ns I        | İslaı     | nd Rd.                                  | Edg                    | gewate                          | er. l          | MD 21037                                  |
| Physician<br>/Medical  |                  | 23a. Part I. Enter the disease, o failure. List only one cause  |                               | that caused                           | the death.    | Do not enter t               | he mode of d                 | ying, su | uch as ca   | rdiac or  | respiratory ar                          | rest, sl               | hock, or hea                    | rt             | Approximate Interval<br>Between Onset and |
| aminer   |                  | Immediate Cause (Final disease or condition resulting in death) |                               |                                       |               | cular Dise                   | ase compl                    | icated   | d by Er     | vironn    | nental Hyp                              | erthe                  | ermia                           |                | Oeath                                     |
|  |                  |   | Oue to (                      | or as a conse                         | equence of    | ):                           |                              |          |             |           |   |                        |                                 |                |   |
|  | er               | Sequentially list conditions,<br>if any, leading to immediate   | Oue to (                      | or as a cons                          | equence of    | ):                           | <u> </u>                     |          |             |           |   |                        |                                 |                |   |
|  | Examiner         | cause. Enter Underlying Cause (Disease or injury that initiated | C                             |                                       |               |                              |                              |          | •           |           |   |                        |                                 |                |   |
| ecuted<br>and<br>transit   | Еха              | events resulting in death) Last                                 | Oue to (                      | or as a cons                          | equence of    | ):                           |                              |          |             |           |   |                        |                                 |                |   |
| execuian and   | n/Medical        | UNPENOEO  | X AME                         | NOEO MEL C                            | 2072 1        | 0/9/07 1                     |                              |          |             |           |   |                        | <del></del>                     |                |   |
| 760, ficate be ex g physician the burial   | Med              | IF FEMALE:  | 23c.                          | If yes, outcor                        | me of pregn   | 0/9/0/ `<br>ancy             | Т                            |          |             |           |   | 2                      | 3d. Oate of                     | delivery       |   |
| Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans   | Physician/       | 23b. Was decedent pregnant in past 12 months?  1 Yes 2 No 9 Ur  | 4                             | Live birth<br>Pregnant at             |               | ath                          | etal death<br>ther (Specify, |          | Ectopic     | pregnan   | су                                      |                        | Month                           | 0              | ay Year                                   |
| he des   | hy               | Part II. Other significant cond                                 | 9                             | Unknown                               | h hut not ro  | culting in the               | undarlying on                | uco giv  | on in Par   | + 1       | 23e Oid                                 | tohacc                 | o use contrib                   | oute to t      | he cause of death?                        |
| ords, P.O. w requires that the ts been signed by t   | by I             | Tartii. Other sigimicani cond                                   | tions contin                  | ding to deat                          | ii but not re | suiting in the               | underlying ca                | use giv  | ÇITILI F EN | ( 1.      |   |                        |                                 |                | ably 4 Unknown                            |
| duires   | ted              |   |                               |                                       |               |                              | •                            |          |             |           | 24a. Was                                |                        |                                 |                | opsy findings available                   |
| Records, The law require ficate has been si  | l ple            |   |                               |                                       |               | · · · · · · ·                |                              |          |             |           | auto<br>perfe                           | psy<br>ormed           | pı                              |                | ompletion of cause of                     |
| tal Recian: The certificate  | Completed        |   |                               |                                       |               |                              |                              |          |             |           | 1 🗸 Yes                                 |                        |                                 | <b>✓</b> Ye    | s 2 No                                    |
| Vital  <br>ystcian:<br>his certifi<br>director,  | Be               | 25. Was case referred to medic examiner?                        | Hospital:                     |                                       |               | FD:0 : "                     |                              | 10       | f Death (   |           |   | 1                      |                                 | -              |   |
| of Vital  ig Physician  Of the certion of the certi | 유                | 1 ✓ Yes 2 No<br>27. Manner of Death                             | 28:                           | Date of Init                          | irv I         | ER/Outpatien<br>28b. Time of |                              | `        | at Work?    |           | Home 5<br>28d. Describe                 |                        | dence 6                         |                | Scene                                     |
| ion of tending Pheath.   | ation:           | 1 Natural 5 Per   | ding F                        | (Month, Day, Y<br>DUND:<br>1 27, 2007 | (ear)         | FOUND:<br>1415 hrs           |                              |          | s 2 🗸       | lo        | Subject exp                             |                        |                                 |                | ment                                      |
| Division pital or Attendit ours after death. teral Director: A   | Certification:   | 3 Suicide 6 Cou   | ild not be 28                 | e. Place of In<br>pecify) Sir         |               | me, farm, stre<br>ily Home   | et, factory, of              | fice bui | lding, etc  | 1         | 28f. Location<br>or Town,<br>3112 Two F |                        |                                 |                | ral Route Number, City                    |
| Divis  To the Hospital or A within 24 hours after To the Fineral Dire  | Medical C        | 20a Certifier   | hysician: To<br>aminer:On the |                                       |               |                              |                              |          |             |           |   |                        |                                 |                |   |
| To To  | Med              | 29b. Signature and title of certif                              | and ma                        | anner stated.                         |               |                              |                              |          | number      |           |   |                        |                                 |                | oth, Day, Year)                           |
|  | 5                | 1 anter   | kery                          | 0                                     |               |                              |                              | C.M      |             |           |   | 1                      | ly 28, 200                      | ,              | , = -,.                                   |
| 10/64  |                  | 3 Name and address of person Laron Locke MD.                    | n who complet<br>Assistant M  |                                       |               |                              | n Street, B                  | altimo   | ore, ME     | 2120      | )1                                      |                        |                                 |                |   |
| Si<br>Regis  | tate<br>trar     | 31. Date filed (Month, Day, Year                                | 1 2007                        | 32. Registra                          | ar's Signatu  | B A                          | and's                        |          |             |           | ·                                       |                        |                                 |                |   |
| OHMH 17 Rev 1/2  |                  |   |                               |                                       |               | ORIGINA                      | L                            |          |             |           |   |                        |                                 |                |   |

OHMH 17 Rev 1/2001 OCME 2006

|                   |  |                   | For<br>State<br>Registrar  | State of Maryla   |  | artment of F<br>rtificate of I  |  | -                                     | giene<br>Reg. No.  |  |
|-------------------|--|-------------------|--|---|--|---|--|---------------------------------------|--|--|
| *                 | Physici  | -                 | 1. Decedent's Name (First, Middle, Las<br>Mary Alice Lare  | t)  |  |   |  | 2. Date of De<br>Month<br>August      | Day Year   | 3. Time of Death 4:30 A M                          |
| No.               | /Medic<br>Examir<br>Funeral<br>Director  | er                | Usual Residence of Decedent  | ex<br>□ M 2 <b>X</b> F  | s. last birthday) 82 Yrs. City, Town or Lo | Hampste<br>If Under 1 Year<br>Months Days                                     | r Location of Death ad If Under 24 Hrs. Hours Min.     | 8. Date of Bin<br>(Month, Da<br>Dec 2 | 4c. County of Death  Carroll  h y Year)  9. Birth  | nplace (State or Foreign                           |
|                   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Directo           | Maryland Carroll  10e. Street and Number  1359 Lare Street   | Ha  | ampstead                                   | 10f. Zip Code<br>21074  |  |                                       | 10g. Citizen of What Coo<br>United Stat  | •  |
| 036               | ours after death<br>ral", or items 2<br>Examiner mus   | by Funeral        | 11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced   | 12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: |  | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 🏅 No                   | ispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No<br>Rican, etc.)       | 14. Race - Amer<br>Black, White<br>Specify: Wh   | e, etc.  |
| 21215-0036        | ed within 72 ho<br>ygiene.<br>Ier than "natui<br>t, the Medical  | Completed         | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)  | de completed) College (1-4or 5+)  | (Give                                      | dent's Usual Occup<br>kind of work done of<br>DO NOT use retired<br>LCal supp | during most of work<br>i)<br>ort super                 | visor                                 | 16b. Kind of Business/I  |  |
| Maryland          | ould be file<br>Mental Hy<br>arked oth   | To Be             | 17. Father's Name (First, Middle, Last) Elias Sterling Br  |   |  |   | 18. Mother's Name                                      |                                       | Maiden Surname)  |  |
|                   | es 1 and 2 sho<br>of Health and I<br>f item 27 is me<br>ir other trauma  |                   | 19a. Informant's Name/Relationship (Margery G. Ayers   | **  | 1  |   |  |                                       | er, City or Town, State, Z<br>Maryland 2   |  |
| Baltimore,        | Pages 1 ament of He ant; If item   |                   | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify   | Removal from State  | cemetery, cree<br>ampsteac                 | sition (Name of<br>matory or other place<br>Cemeter                           | Aug. 20  | 07                                    | 20c. Location - City or Hampstead,   |  |
| Ball              | permit. Depart Import any in   |                   | 21. Signature of Funeral Service Usen  | ° M01   |  | 2. Name and Addre   |  | ine Fun<br>et Ham                     | eral Home<br>pstead, Md.   | 21074  |
| · STATE OF STREET | Physician<br>/Medical<br>Examiner  | ner               | 23a. Part1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  | a.  Due to (or as a cons  | 2(AN<br>equence of):                       | er the mode of dyin   | ng, such as cardiac                                    | or respiratory a                      | rest,  | Approximate<br>Interval Between<br>Onset and Death |
| x 68760,          | certificate be executed ding physician and se as the burial-transit  | /Medical Examiner | If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | CDue to (or as a cons   |  |   |  |                                       | 23d Date of deli   |  |
| P.O. Box          | it the death certif<br>by the attending<br>tached for use as   | Physician/Me      | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  | 1 ☐ Live birth 2 ☐ Fe<br>4 ☐ Pregnant at time o<br>9 ☐ Unknown                    | etal death 3                               | ⊒Ectopic pregnancy<br>⊒Other (s <i>pecify)</i>                                | ′  |                                       | 23d. Date of deli<br>Month   | Day Year   |
|                   | w requires that the death certif<br>been signed by the attending<br>should be detached for use a:  | by                | Part II. Other significant conditions of   | ontributing to death but not r  | esulting in the u                          | nderlying cause giv   | en in Part I.  | 23e. Did to                           |  | obably 4 Unknown                                   |
| or Vital Records  | The lar<br>ate has<br>page 2   | Be Completed      | 25. Was case referred to medical examiner?   |   |  |   | 26. Place of Deat                                      | autor<br>perfo<br>1∐ Yes              | prior to death?  2 No 1 Yes  | topsy findings available completion of cause of    |
| sion or V         | ng Phys<br>fter this<br>ineral dir   | 은                 | 1 Yes 2 No  27. Manual of eath 1 Natural 5 Pending investigation   | 28a. Date of Injury<br>(Month, Day Year)  | ER/Outpatier<br>28b. Time o<br>Injury      | f 28c. Injur<br>Wor   | 4 □ Nursing Ho   |                                       | dence 6 Other (Special Control of the Control of th | city)  |
| Division          | To the Hospital or Attendi within 24 hours after death.  To the Funeral Director; A completely filled in by the fu   | Certification:    | 3 ☐ Suicide 6 ☐ Could not be determined  | building, etc. (Spe   | cify)                                      |   |  | City or Tou                           |  |  |
|                   | the Hosp<br>in 24 hou<br>the Fune<br>apletely fil  | Medical           | (Check only one) 2 Medical Exam  | yeiclan: To the best of my kinner: On the basis of examined and manner stated.    | nowledge, deat<br>ination and/or in        | vestigation, in my o  | pinion, death occur                                    | and due to the red at the time,       | date and place, and due  | to the cause(s)                                    |
| )                 | WIL  | 2                 | 29b. Signature and title of certifier  |   | 25.17                                      | 29c. Licens   | 9303 l   |                                       | 29d. Date signed (Month  | n, Day, Year)                                      |
|                   | ID   |                   | 30. Name and address of person who outsure (who have been address of person who outsured the state of the sta | 50mpleted cause of death (It  | Carta                                      | Print)<br>Street  | Westn  | nuste                                 | -,MD2115   | 7  |
|                   | Sta<br>Registi   |                   | //-  |   | , J.                                       | Sperte  |  |                                       |  |  |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Thomas Linthicum Austin July 26, 2007 7:35 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 302 Cathedral Place Glen Burnie If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Feb. 13, Anne Arundel 5. Social Security Number 7 Age (In vrs. last hirthday) Birthplace (State or Foreign Country) **Funeral** S. 1947 Maryland Months 1 √M 2 □ F 231-68-7328 60 Director Usual Residence of Decedent the Maryland 10a. State 10h Counts 10c. City. Town or Location 10d. Inside City Limits i Hygiene. other than "natural", or Itema 23a or 28a-f ehow vent, the Madical Examiner must be notified at MD 1 ☐ Yes 2 ☑ No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 Cathedral Place Funeral 21061 <u>United States</u> death permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If lem 27 is marked other trainmany injury or other trainmany. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Audio Professional Entertainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Linthicum Lola Shrive 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Wickers (friend) 302 Cathedral Place Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cometery, crematory or other place National, Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State July 31, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □Other (Specify) 2007 Falls Church, Virginia 22. Name and Address of FacilityAdvent Funeral & Cremation Ser. 21. Signature of Fundral M00982 7211 Lee Hwy. Falls Church, Virginia 22046 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 3 y leer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner inding physicien and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death ed by the a 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? has certificate 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA his 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the e 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie. 21438 20 D OK Name and address of person And completed cause of death (Item 23a) (Type, Print) GEHWAN ANNARUS MORIFUL DEFENSE TAMA 44 nichan CN 32. Register's Signature 31. Date filed (Month, Day, Year) State 3 0 2007 Registrar

|          |   |                | For<br>State<br>Registrar   |  | State of Ma   | aryland /                               |                   | artment of F                                |                             | l Mental H                              | ygien<br>Reg. N              | 1               | - Laboratoria                         | 21          | 321,                |
|----------|---|----------------|---|--|---|---|-------------------|---|-----------------------------|---|------------------------------|-----------------|---------------------------------------|-------------|---------------------|
|          | 1100  | 53             | Decedent's Nam  | ne (First, Middle, La                    | st)   | -                                       |                   |   |                             | 2. Date of                              | Death                        |                 |                                       | 3. Time     | of Death            |
|          | Physici<br>/Medic   |                | Mary Pa   | atricia M                                | ayne  |   |                   |   |                             | Month                                   | 20                           |                 | 2007                                  | 23          | <i>3</i> 9 м        |
| 1        | Examir  |                | 4a. Facility Name (   | . 1                                      | e street and number)                                    | 41                                      |                   | 4b. City, Town, o                           |                             | - 1                                     | 40                           | c. Coun         | ty of Death                           |             |                     |
|          |   |                | Sinai   | Hospi                                    |   | attimo                                  |                   | Balt<br>If Under 1 Year                     | If Under 24 H               |   |                              | 1/A             |                                       |             |                     |
|          | Funeral<br>Director   |                | 5. Social Security N<br>219–66–36.  | 1 .                                      | - FR -  | e (In yrs. last bi<br><b>54</b>         | Yrs.              | Months Days                                 | Hours Mi                    | n. (Month,                              | Day, Yea <i>i</i>            |                 | Cour                                  | itry)       | or Foreign          |
|          |   | ĺ              | Usual Residence o   |  |   |   |                   |   |                             | May 3                                   | , 195                        | 13              | Mary.                                 | rand        |                     |
|          | rylan<br>rhow   | _              | 10a. State  | 10b. County                              |   | 10c. City, Tov                          | vn or Lo          | cation                                      |                             |   |                              |                 | 1                                     |             | City Limits         |
|          | Ba-f s  | Director       | MD  | Carroll                                  |   | Mt.Air                                  | У                 | T   |                             |   | 1.0                          |                 |                                       |             | es 250 No           |
|          | death with the Maryland<br>ms 23a or 28a-f show<br>r must be notified at  |                | 10e. Street and Nu 6501 Buf:  |  |   |   |                   | 10f. Zip Code <b>21771</b>                  |                             |   |                              |                 | f What Cour                           |             |                     |
|          | ns 23<br>musi   | Funeral        | 11. Marital Status  | Lato Ru.                                 | 12. Was Decedent I                                      | Ever in U.S.                            | 13.               | Was Decedent of H                           | lispanic Origin?            | (Specify Yes or                         |                              |                 | l State                               |             |                     |
| -0036    | be filed within 72 hours after death with the Marylar ital Hyglene.  d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | þ              |   | ried <b>ŽQM</b> arried<br>4 ☐ Divorced   | Armed Forces? 1 ☐ Yes 2 ♣ ↑ If Yes, Give Year or Dates: | No                                      |                   | If Yes, specify Cuba<br>1 ☐ Yes 2 No        | an, Mexican, Pu<br>Specify: | erto Rican, etc.)                       |                              | Spec            | ack, White,<br>cify: Wh               | etc.<br>ite |                     |
| ဂ<br>ဂ   | 72 hc   | Completed      | (Spe  | 15. Decedent's E                         | ducation<br>ade completed)                              | 168                                     | (Give             | dent's Usual Occup<br>kind of work done     | durina most of v            | vorking                                 | 16b. I                       | Cind of         | Business/In-                          | dustry      |                     |
| 7        | within<br>ene.<br>than '  | Ig III         | Elementary/Second   | ondary (0-12)                            | College (1-4or 5  |   |                   | DO NOT use retired<br>emaker                | d)                          |   | he                           | r h             | omo                                   |             |                     |
| D<br>D   | filed<br>Hygid<br>Sther<br>ent, th  |                |   | (First, Middle, Last                     | )   |   | 110111            | enaker                                      | 18. Mother's N              | lame (First, Midd                       |                              |                 |                                       |             |                     |
| a<br>a   | lid be lental rked o  | To Be          | Dwight Ma   | ason Blai                                | r   |   |                   |   | Bessie                      | Stevens                                 |                              |                 |                                       |             |                     |
| Mary     | s 1 and 2 should be<br>f Health and Mental<br>item 27 is marked<br>other traumatic ev   | -              |   | ame/Relationship (                       |   |   |                   | ng Address (Street                          |                             |   |                              |                 | n, State, Zip                         | Code)       |                     |
|          | and<br>saith<br>127<br>er to  |                | 20a. Method of Dis  |  | Jr. (Husb   |   |                   | Buffalo sition (Name of                     | Ra. Mt.                     | Date                                    |                              |                 | n - City or To                        | was State   |                     |
| baitimor | t. Page<br>tment o<br>tant: If<br>ijury or  |                | <b>IXX</b> Burial 2<br>4 ☐ Donation   | ☐ Cremation 3 ☐ 5 ☐ Other (Special       |   | cemete                                  | ery, crei<br>11 S | prings Ce                                   | em 8/3/                     | 2007                                    |                              |                 | y, MD                                 | , Otate     |                     |
| g        | permi<br>Depar<br>Impor<br>any Ir   |                | 1   |  | ellen   |   | Eu<br>12          | 2. Name and Addre<br>rrier-Que<br>12 W. Old | en Fune<br>Libert           | v Rd. W                                 | infic                        | l Cr            | emato:<br>MD 2                        | 1784        |                     |
|          |   |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Conset and |  |   |   |                   |   |                             |   |                              |                 |                                       |             | etween              |
|          | Physician<br>/Medical   |                | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) last   |  |   |   |                   |   |                             |   |                              |                 |                                       | 481         | US                  |
|          | Examiner  |                |   | - 6                                      | CO WA DV  | a consequi noe                          | e or):<br>•       | atolock                                     | 1616                        |   |                              |                 |                                       | ual         | L LC                |
|          |   | ner            | Sequentially list co<br>if any, leading to in<br>cause. Enter Undo<br>Cause (Disease or   | onditions,<br>mmediate                   | b. Due to ( ) as  | a consequence                           | of):              | 0,0.0                                       |                             |   |                              |                 |                                       |             | <u> </u>            |
|          | ecuted<br>ind<br>transit  | Examiner       | Cause (Disease or that initiated event resulting in death)  | S  | · pulmo   | el                                      | dema              |   |                             |   |                              |                 | n81                                   | WS          |                     |
| Ď,       | icate be executed<br>physician and<br>s the burial-transit  |                | resulting in death)   | Last                                     | Due to (or as   | a consequer e                           | ot):              |   |                             |   |                              |                 |                                       |             |                     |
| 08/pn    | physi<br>physi<br>s the b   | dical          |   | •  | d   |   |                   |   |                             |   |                              |                 |                                       |             |                     |
| XOD      | requires that the death certificate be executed<br>een signed by the attending physician and<br>nould be detached for use as the burial-transit                         | Physician/Me   | IF FEMALE;<br>23b. Was deceder  | nt pregnant                              | 23c. If yes, outcome                                    |   |                   | 7   |                             |   |                              | 23d. E          | Date of delive                        | ery         |                     |
| מ        | death<br>e atte   | icia           | in the past 12<br>1 ☐ Yes 2   | 2 months?                                | 1□Live birth<br>4□Pregnant at<br>9□Unknown              |   |                   | ]Ectopic pregnancy<br>]Other (specify) _    | /                           |   | _                            | N               | Month                                 | Day         | Year                |
| ν.<br>Σ  | w requires that the de<br>been signed by the<br>should be detached  | hys            | 9 ☐ Unknow  |  |   |   |                   |   |                             |   |                              |                 |                                       |             |                     |
| s,       | res th  |                | Part II. Other signi  | ificant conditions                       | contributing to death be                                | ut not resulting                        | in the u          | nderlying cause giv                         | en in Part I.               |   |                              | use co<br>2  No | ntribute to t<br>3 ☐ Prol             |             | f death?<br>Unknown |
| cords,   | requi   | sted           | LIGM  | unex                                     | a mas=  |   |                   | Γι  |                             | -                                       |                              | 1               |                                       | /           |                     |
| Š        | The law<br>ate has b  | ompleted by    | sup ex  | plovaro                                  | ny lapar  | oromi                                   | y n               | 1th 1A                                      | 4 350                       |   | as an<br>itopsy<br>erformed? |                 | o. Were auto<br>prior to co<br>death? | mpletion o  |                     |
| VITAI    | 29  | မ<br>လ         | 25. Was case refe   | rred to medical                          |   |   |                   |   | 00 Diago of F               | 1X Ye                                   | s 2□N                        |                 | 1 ☐ Yes                               | 2 No        |                     |
|          | Attending Physician: r death. ector: After this certific by the funeral director,   | 0 B            | examiner?   | No                                       | Hospital: 1 Inpatie                                     | ent 2 ☐ ER/O                            | utpatier          | nt 3□ DOA Oth                               | er:                         | Death <i>(Check on:</i><br>g Home 5 ☐ R |                              | 6 □C            | other (Specia                         | fv}         | <del></del>         |
| ם ר      | ding Phys<br>n.<br>After this<br>funeral di   | ı.             | 27. Manner of Dea   | -  | 28a. Date of Inju<br>(Month, Day                        | ry 28b.                                 | Time o            | f 28c. Inju                                 |                             | 28d. Describ                            |                              |                 |                                       | ,,          |                     |
| UNISION  | endir<br>eath.<br>or: Af  | atic           | 2 Accident  | 5 ☐ Pending investigatio 6 ☐ Could not b | n   |   |                   | M 1 🗆                                       | Yes 2 □ No                  |   |                              |                 |                                       |             |                     |
| Ž        | or Att<br>fter de<br>Direct<br>in by t  | Certification: | 3 ☐ Suicide<br>4 ☐ Homicide   | determined                               |   | ury - At home, f<br>c. <i>(Specify)</i> | arm, str          | eet, factory, office                        |                             | 28f. Location<br>City or                | n (Street a<br>Town, Sta     | ind Nun<br>te)  | mber or Run                           | al Route N  | umber,              |
| _        | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.        | Ce             | 29a, Certifier  | 1 Certifying P                           | nyslcian: To the best                                   | of my knowledo                          | ne. deat          | h occurred at the ti                        | me, date and ni             | ace, and due to t                       | he cause(                    | s) and          | manner as s                           | tated.      |                     |
|          | e Hos<br>124 h<br>e Fur   | edical         | (Check only one)  | 2☐ Medical Exa                           | miner: On the basis of<br>and manner sta                | f examination a<br>ated.                | ind/or in         | vestigation, in my                          | ppinion, death o            | ccurred at the tir                      | ne, date a                   | nd place        | e, and due t                          | o the caus  | e(s)                |
|          | To th<br>withir<br>To th<br>comp  | Me             | 29b. Signature and  | title of certifier                       | . 15  |   |                   | 29c. Licens                                 | e number                    |   | 29d. D                       | ate sigr        | ned (Month,                           | Day, Year   | )                   |
|          | WJL   |                | <b>▶</b> \( \lambda \)  | ulle,                                    | W)  |   |                   | 2-6   | 5000                        |   | 2                            | 5 1             | 120                                   | 77          |                     |
|          | 4   |                | 30. Name and add  | - 11 - 1                                 | completed cause of d                                    | eath (Item 23a)                         | (Type,            | Print)  Print)                              | bu served                   | 2401                                    | W.F                          | 地儿              | reder                                 | e Ave       | · ·                 |
| W        | Sta   | ate            | 31. Date filed (Mor   |  | 32. Registra  | ar's Signature                          | NE                | JET DU                                      | THEYE                       | Ba                                      | u,                           | MI              | 1 217                                 | 45          |                     |
|          | Regist  |                | ,,,,,,  | AUG 01                                   | 2007  | we b                                    | 4                 | books                                       |                             |   |                              |                 |                                       |             |                     |
| DHI      | MH 17 Rev 1/2   | 001            |   |  |   |   | -7                |   |                             |   |                              |                 |                                       |             |                     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Jack Lester McCauley, Sr. 1002 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 X M 2 □ F Director 220-28-9010 73 Nov. 19, 1933 Maryland Usual Residence of Decedent build be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County or 28a-f show notified at show 1 ☐ Yes 2 X No Director Maryland Washington Williamsport 10e. Street and Number 10g. Citizen of What Country? ms 23a or ; must be r 14808 Bottom Road 21795 Funeral "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 1954— If Yes, Give Black, White, etc 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced White Year or Dates: 1956 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than the Maintenance Supervisor |Commercial Apartment Const. alth and Mental Hygie 27 Is marked other r traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic ev P Sara Jane Timmons Charles Edmond McCauley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley M. McCauley - Wife 14808 Bottom Road Williamsport, Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cedar Lawn Mem. Park Aug. 4,2007 | Hagerstown, Maryland 21. Sig / ture of Funeral Osberne Afternetterity Home, P.A. 21795 425 S. Conococheague St. Williamsport, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that little ted events Examiner and burial-trar resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 Yes 2 No 9 Unknown Park U. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed' certificate Be 25. Was case referred to medical director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 LAK 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Beath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 ☐ Pending investigation 1 TYes 2 □ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The law requires that the death certificate be executed or Vital Records, P.O. Box 68760, signed by the a d be detached for Physician: this or Attending death. within 24 hours after deat To the Funeral Director: To the Hospital completely

Baltimore, Maryland 21215-0036

State

DHMH 17 Rev 1/2001

JH 4+1

Registrar

29b. Signature and title of certifier

30. Name and address

leted cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 0700 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ional medical Cente 8. Date of Birth (Month, Day, Year) 4-28-19 Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗷 F 83 Yrs. 216-18 Director MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits SALISBURY 1XYes 2 □ No MARYLAND Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21801 SENIOR U.S.A. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ZKNo Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature any injury or other traumatic event, the Medical once." 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DomEstic NONE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WINDER Lillie MONROE JACKSON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anchors Way Md 21801 N)ARiA DAUGHTER DALSDURY ARS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Rurial 2 □ Cremation 3 □Removal from State CEMETERY HEBROW, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address Facility FUNERA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ELOGENOUS

Physician /Medical Examiner

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

"natural", or items 23a or 28a-f show edical Examiner must be notified at

attending p ed by the a been signed be should be detailed certificate has b rector, page 2 sl

Division or Vital Records, P.O. Box 68760,

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

BALBADO

AUG 0 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hours after death.

To the Funeral Director: /

To the Hospital or Attending Physician: The law requires that the death certificate be executed

|             |  | Due to (or as a consequence of):   |  |                                |  |  |  |  |  |  |  |
|-------------|--|--|--|--------------------------------|--|--|--|--|--|--|--|
|             | Comments to the same of the same   | PHIZIM OHIA  |  | 3 Days                         |  |  |  |  |  |  |  |
| ner         | Dequentially list conditions, if any, leading to immediate cause. Enter Underlying       | Due to (or as a consequence of):   |  | 0 1                            |  |  |  |  |  |  |  |
| ā           | Cause (Disease or injury that initiated events   | · RIZHAL INSUITECTENCY   | 3 PAKS   |                                |  |  |  |  |  |  |  |
| Ĭ           | resulting in death) Last   | Due to (or as a consequence of):   |  |                                |  |  |  |  |  |  |  |
| ica<br>ica  |  |  |  |                                |  |  |  |  |  |  |  |
| nysician/me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ √No 9 □ Unknown | 23c. If yes, outcome pf pregnancy  1  Live birth 2 Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5 Other (specify)  |  |                                |  |  |  |  |  |  |  |
| led by PI   | DIABETES MA  | ontributing to death but not resulting in the underlying cause given in Part I.  | 23e. Did tobacco use contribute to   |                                |  |  |  |  |  |  |  |
| npie        | ATHEROSCLIERO +10 HEADTI DISCASE 24a. Was an autopsy prior to co                         |  |  |                                |  |  |  |  |  |  |  |
| 5           |  | ARDUNGO CYTHERUIN  | performed? death? 1□ Yes 2 No 1 □ Yes  | s 2□No                         |  |  |  |  |  |  |  |
| ย           | 25. Was case referred to medical examiner?   | 26, Place of Death (   |  |                                |  |  |  |  |  |  |  |
| 2           | 1 ☐ Yes 2 ☐ No   |  | e 5 ☐ Residence 6 ☐ Other (Spe   | ecify)                         |  |  |  |  |  |  |  |
| ation:      | 27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation                   | (Month, Day Year) Injury Work?  M 1 ☐ Yes 2 ☐ No   | d. Describe how injury occurred  |                                |  |  |  |  |  |  |  |
| erunc       | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)   | f. Location <i>(Street and Number or R</i><br>City or Town, State)           | ural Route Number,             |  |  |  |  |  |  |  |
| Car         | 29a. Certifier 1 Certifying Ph   | ysician: To the best of my knowledge, death occurred at the time, date and place, an iner: On the basis of examination and/or investigation, in my opinion, death occurred | nd due to the cause(s) and manner a<br>d at the time, date and place, and du | s stated.<br>e to the cause(s) |  |  |  |  |  |  |  |

29c. License number

UP40 SAUSKUM

29d. Date signed (Month, Day, Year)

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State

Registrar

|   |                                     | 1  | For<br>State<br>Registrar   | State of Man   | yland / Depa   |  |  | /lental Hyg  | giene 0 7 7   | 26240  |
|---|-------------------------------------|--|---|--|--|--|--|--|---|--|
| /M  | /siciar<br>ledica<br>amine          | 1  | Gerrit Nieuweboe  a. Facility Name (If not institution, give  | r  |  |  | or Location of Death   | 2. Date of Dea<br>Month<br>Jin / 9   | Day Year 30 200 7 4c. County of Deat  | 3. Time of Death                               |
| Fune<br>Direc   |                                     |  | 80 Leicester Way  5. Social Security Number  221-26-2035  Usual Residence of Decedent   | 7. Age (I  | n yrs. last birthday)<br>80 Yrs.   | Chesapea<br>If Under 1 Year<br>Months Days   |  | 8. Date of Birth (Month, Day Nov. 1  | Cecil h y, Year) 7,1926 Neth  | hplace (State or Foreign<br>untry)<br>nerlands |
|   | event, the Medical                  | o be completed by rullelal billector                                 | Maryland Cecil 10e. Street and Number  80 Leicester Way 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ediceptory only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Johan Nieuweboer | 12. Was Decedent Eve<br>Armed Forces?<br>1 ☐ Yes 2 No<br>If Yes, Give<br>Year or Dates:<br>Judation<br>de completed)<br>College (1-4or 5+)   | 16a. Dece<br>Give<br>life.<br>Elect  | Ake City  10f. Zip Code  2191  Was Decedent of If Yes, specify Cub  1 Yes 2 No  dent's Usual Occu, kind of work done DO NOT use retire | dispanic Origin? (Span, Mexican, Puerto Specify:  pation during most of work of the parton of the pa | pecify Yes or No-<br>Prican, etc.)  sting  e (First, Middle,   | Specify: Whi  16b. Kind of Business/  Medical Equ  Maiden Sumame)  en   | ces rican Indian, e, etc. te Industry ipment   |
| s 1 ar<br>if Hea<br>item  | any injury or other traumatic once. | - 2  | 19a. Informant's Name/Relationship (T. Magda J. Nieuwebo 10a. Method of Disposition 1 □ Burial 2 A Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify, 21. Signature of Juneral Service Licens   | er/wife Removal from State   | 80 Le 20b. Place of Dispo<br>cametery, crar R.T. Foat Home                   | eicester sition (Name of natory or other pla rd P.A Name and Addre   | Way, Ches  | sapeake<br>Date<br>2-2007<br>C. Foard  | City, MD 21 City, MD 21 20c. Location City or Rising Sun, Funeral Ho Sun, MD 2191   | .915<br>Town, State<br>Maryland<br>ome, P.A.   |
| death certificate be executed Camping biysician and drouge as the brightness to the | cal ner riansii edical Examiner     | Tedical Certification; To be completed by Physician/Medical Examiner | f any, leading to immediate Cause (Disease or injury hat initiated events resulting in death) Last  | Due to (or as a condition of the conditi | onsequence of): onsequence of): oregnancy                                    | n Sun S  |  | S.R.   | 23d. Date of deli   | •  |
| hat the d by th   | be detached                         |  | 1   Yes 2   No<br>9   Unknown   | 4 Pregnant at tim<br>9 Unknown<br>ntributing to death but n  |  | Other (specify) _  | ven in Part I.   |  | bacco use contribute to   | 1  |
| DIVISION OT VITAL HECONDS,  To the Hospitel or Attending Physician: The law requires t within 24 hours after death. To the Funderied Directors: After this certificate has been signe commission in but he funder director hand 2 should but  | ton: To Be Comp                     |  | 17. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined 29a. Certifier (Check only one) 1 Certifying Physics (Check only one)  | Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (3 sician: To the best of more: On the basis of exand manner stated   | At home, farm, str<br>Specify)<br>ny knowledge, death<br>amination and/or in | 28c. Inju Wo  M 1 == eet, factory, office  | Yes 2 ☐ No   | h Check onl or one 5 A Resid 28d. Describe h 28f. Location (S City or Tow and due to the cred at the time, d | sy prior to c death? 2/2/No 1 Yes  ne  lence 6 Other (Spectow injury occurred  Street and Number or Rum, State)  cause(s) and manner as date and place, and due | ral Route Number, stated. to the cause(s)      |
| Townst Towns  | 3                                   |  | 19b. Signature and little of certifier  H Fark 45.  | cas, Minimpleted cause of death  | (Item 23a) (Type,  | Print)   |  |  | 29d. Date signed (Month  1 1/2 30, 20  541/7 C, 4   |  |
| Reg   | State<br>gistrar                    |  | AUG 1 2007  | 32. Registrar's  | Signature  | ,  | 1  | 1  |   |  |

DHMH 17 Rev 1/2001

|                   |   |                     | For State Registrar  | tate of Maryland  | •  | ment of H  |   |  | giene<br>Reg. No.               |  | うらうは可   |
|-------------------|---|---------------------|--|---|--|--|---|--|---------------------------------|--|---|
|                   | Physici   |                     | 1. Decedent's Name (First, Middle, Last)  JANEL  |   |  | N  | OLL   | 2. Date of De<br>Month                 | ath<br>Day                      | Year   | 3. Time of Death                              |
|                   | /Medic<br>Examin<br>Funeral<br>Director   |                     | 4a. Facility Name (If normstitution, give street)  5. Social Security Number  6. Sex   | et and number)  7. Age (In yrs. le  | ospital  |  | Location of Death  If Under 24 Hrs.  Hours Min. | 8. Date of Bird<br>(Month/Da<br>June 2 | 4c. Cour<br>n<br>th<br>y, Year) | Coun   | lace (State or Foreign                        |
|                   | Maryland<br>a-f show<br>ified at  | tor                 | Usual Residence of Decedent  10a. State 10b. County  PA Lancaster  |   | , Town or Locati                                       |  |   |  |                                 |  | 0d. Inside City Limits 1 □Yes 2X No           |
|                   | with the<br>a or 28a<br>t be not  | Direc               | 10e. Street and Number   |   |  | 10f. Zip Code<br>17603   |   |  | 10g. Citizen o                  | of What Cour                                     |   |
| 960               | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or items 23a or 28a-f show<br>ant, the Medical Examiner must be notified at   | by Funeral Director | 1 ☐ Never Married 2 🛣 Married  | Was Decedent Ever in U.S<br>Armed Forces?<br>1  |  |  | ispanic Origin? (Sp<br>an, Mexican, Puerto      | pecify Yes or No<br>Rican, etc.)       | Spe                             | lace - Americ<br>lack, White,<br>cify: Whit      | an Indian,<br>etc.<br>C C                     |
| 21215-0036        | within 72 h   | Completed           | 15. Decedent's Educati<br>(Specify only highest grade co   |   | (Give kind<br>life. DO                                 | t's Usual Occup<br>d of work done o<br>NOT use retired<br>Eacilita   | during most of worl<br> )                       | king                                   | 16b. Kind of Hosp:              | Business/Ind                                     | dustry  |
| Maryland 2        | iges 1 and 2 should be filed within 72 hc<br>to f Health and Mental Hygiene.<br>If item 27 is marked other than "natur<br>or other traumatic event, the Medical   | To Be Co            | 17. Father's Name (First, Middle, Last) Herman C. Ruof   |   | OHIL I   |  | 18. Mother's Nam                                | ne (First, Middle,                     | , Maiden Surn                   |  |   |
| Mary              | d 2 shouth and N is man   |                     | 19a. Informant's Name/Relationship (Type. Lance No11/husband   | Print)  |  |  | and Number or Ru<br>Manor D                     |  | -                               | -  |   |
| Baltimore, I      | permit. Pages 1 and 2<br>Department of Health a<br>Important: If item 27 is<br>any injury or other tra  |                     | 20a. Method of Disposition  1 Burial 2 Commation 3 Rem 4 Donation 5 Other (Specify)  | oval from State $\mathbb{E}\mathbf{v}_{s}^{ce}$   | lace of Disposition emetery, cremate ans Eagl Services | on (Name of<br>ory or other place<br>Le Crema  | e) i  | Date 2-2007                            | 20c. Locatio                    | n - City or To                                   |   |
| Balti             | permit. Departm Importa any inju  |                     | 21. Signature of Funeral Service Linnsee   | 1   | 22. N<br>111   | ame and Addre  | en St.,   | T. Foard<br>Rising S                   | d Funer<br>Sun, MI              | al Hor   | 1   |
|                   | Physician<br>/Medical   |                     | 23a. Part1. Enter the disease, or complicate shock, or head failure. List only one of immediate Cau (Final disease or con the neath)  a                    | sause on each line.   | umon   | •  | ig, such as cardiac                             | or respiratory a                       | rrest,                          |  | Approximate Interval Between Onset and Death  |
| 8760,             | ate be executed which is a secuted which is a secuted with the purial-transit which is a secuted with the provided with | al Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequ   | al lu  | ng d   | isease  | •                                      |                                 |  | 2 years                                       |
| .O. Box 687       | eath certific<br>attending p<br>for use as  | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown | death 3□Ed   | ctopic pregnancy   | 1   |  | 1                               | Date of delive                                   | ery<br>Day Year                               |
| <u>α</u>          | w requires that the d<br>been signed by the<br>should be detached   | b                   | Part II. Other significant conditions contril  | buting to death but not resu  | ulting in the unde                                     | erlying cause giv  | en in Part I.                                   |  |                                 |  | he cause of death?<br>bably 4                 |
| or Vital Records, | The la<br>ate has<br>page 2   | Completed           |  |   |  |  |   | 24a. Was<br>auto<br>perfo<br>XYes      |                                 | b. Were auto<br>prior to co<br>death?<br>1 ☐ Yes | opsy findings available impletion of cause of |
| Vita              | ician<br>sertifi<br>ector   | Be                  | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hos  | pital:  | ER/Outpatient  | 3□ DOA Oth   | 26. Place of Dea                                |  |                                 | Other (Speci                                     | fv)   |
| Division or       | ng<br>ifter   | Certification: To   | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be  | 28a. Date of Injury<br>(Month, Day Year)<br>28e. Place of injury - At ho                  | 28b. Time of Injury                                    | enter 5 DOA 4 Notising Horite 5 Nesidence 6 Other (specify of Very Notice)  4 Notising Horite 5 Nesidence 6 Other (specify of Very Notice)  4 Notising Horite 5 Nesidence 6 Other (specify of Very Notice)  4 Notising Horite 5 Nesidence 6 Other (specify of Very Notice)  4 Notising Horite 5 Nesidence 6 Other (specify of Very Notice)  4 Notising Horite 5 Nesidence 6 Other (specify of Very Notice)  4 Notising Horite 5 Nesidence 6 Other (specify of Very Notice)  4 Notising Horite 5 Nesidence 6 Other (specify of Very Notice)  4 Notising Horite 5 Nesidence 6 Other (specify of Very Notice)  4 Notising Horite 5 Nesidence 6 Other (specify of Very Notice)  4 Notising Horite 5 Nesidence 7 Neside |   |  |                                 |  |   |
| Ö                 | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu  |                     | 29a. Certifier 1X Certifying Physic  | building, etc. (Specify ian: To the best of my know                                       | wledge, death o  |  |   | and due to the                         |                                 |  |   |
|                   | the Ho  | Medical             | (Check only one) 2  Medical Examiner  29b. Signature and title of certifier  | r: On the basis of examina<br>and manner stated.  | tion and/or inves                                      | 29c. Licens  |   | urred at the time                      | , date and pla                  |  |   |
|                   | 7. w 7. 8   | _                   | 200. Orginal and and or certainer  | MEDICAL DO  | CTOR   |  | -000  |  | _                               |  | , 2007  |
|                   | O   |                     | 30. Name and address of person who comp  |   |  |  | VORTH WOL                                       | fe stree                               | T BALTI                         | MURE n   | 21287   |
| 1                 | St.<br>Regist   | ate                 | 31. Date filed (Month, Day, Year)  | 32. Registrar's Signa   | ture Spare   | 1  |   |  |                                 | 1 -1   | * ************************************        |

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2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 07 73 67 **Physician** Thelma Pearson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Allegany** WMHS Braddock Campus Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 💢 F Director MARYLAND MAR. 4, 1921 220-14-0278 86 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is amarked other than "inatural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Director FORT ASHBY WV MINERAL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 26719 U.S.A. DAN'S RUN ROAD Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: þ 3 Nowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BARNIUM GEORGE WIDERMAN MARY SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. BOX 257, FORT ASHBY, WV WAYNE LINN / COUSIN 26719 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FORT ASHBY CEMETERY 07/22/2007 FORT ASHBY, WV 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility UPCHURCH FUNERAL HOME, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MASSIVE 40 CARDIAL ACUTE **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 5 □ Other (specify) \_\_ 1 Live birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 1∏ Yes 2 HNO To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mas 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland SATURNING CHANG M. D 7160 4 Broadway 32. Registrar's Signature 31. Date filed (Month, Day, Year) 3 2007 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

3. Time of Death

1 ☐ Yes 2 No

215052 Approximate Interval Between Onset and Death

Day

Keurs

Year

0915

DHMH 17 Rev 1/2001

Amended #22, nls,

07/23/07, Allegany Co.

1 - State Registrar

|  |                  | 1 _ State   | State of Maryland                                      |  | it of Health and in<br>e of Death                          |                                       | tim or in                          | 26251  |
|--|------------------|---|--|--|--|---------------------------------------|------------------------------------|--|
|  |                  | Registrar  1. Decedent's Name (First, Middle, Last)   | 0 ===  | Octimoat                                       | e or bearing   | 2. Date of Deat                       |                                    | 3. Time of Death                                   |
| Physic<br>/Med   |                  | Frances   | KOSS   |  |  | Month 7                               | 20 07                              | 2010 M   |
| Exami  |                  | 4a. Facility Name (If not institution, give s   | reet and number)                                       | Pemb Sa  | Town, or Location of Deat                                  | MD                                    | 4c. County of Deat                 | mico   |
| Funeral  |                  | 5. Social Security Number 6. Sex  | 7. Age (In yrs.)la                                     | st birthday) If Under Months                   | 1 Year If Under 24 Hrs<br>Days Hours Min.                  |                                       | Year) Co                           | nplace (State or Foreign<br>untry)<br>ry   Q h d   |
| Director   |                  | Usual Residence of Decedent   | 10   |  |  | 101191                                | 1931 1114                          | J  |
| aryiano<br>Bhow  | _                | 10a. State 10b. County  | 10c. City,   | Town or Location                               | 11   |                                       |                                    | 10d. Inside City Limits 1                          |
| the Mi   | Funeral Director | 10e. Street and Number  | II CO I CU   | 101.2ip  | Code   | 1                                     | 0g. Citizen of What Co             |  |
| h with<br>23a or   | ai Di            | 105 Time :  | Square   | - C  | 21804  |                                       | U.S.                               | A  |
| er dea   | uner             | Tr. Wallar States   | Was Decedent Ever in U.S<br>Armed Forces?              | S. 13. Was Dece<br>ff Yes, spe                 | dent of Hispanic Origin? (S<br>crfy Cuban, Mexican, Puer   | Specify Yes or No-<br>to Rican, etc.) | 14. Race - Ame<br>Black, Whit      |  |
| or elf, or   | b                | 1 ☐ Never Married 2 ☐ Married<br>3 ☐ Wildowed 4 ☐ Divorced  | 1 ☐ Yes 2 No<br>If Yes, Give<br>Year or Dates:         | 1 □ Yes  | 2 No Specify:  |                                       | Specify:                           | lack   |
| natur  | ieted            | 15. Decedent's Educ<br>(Specify only highest grade  | ation<br>completed)                                    | 16a. Decedent's Usu<br>(Give kind of wo        | al Occupation<br>ork done during most of wo<br>se retired) | rking                                 | 16b. Kind of Business/             | Industry   |
| d withir<br>d withir<br>rr then  | Completed        | Efementary/Secondary (0-12)   | College (1-4or 5+)                                     |  | disabled   |                                       | none                               |  |
| Daililliore, Inial yialid A.I.Z.I.D.DOOO permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or itema 23s or 28s-1 show eny injury or other traumatic event, the Medical Exercites must be cottled at eny finity or other traumatic event, the Medical Exercites must be cottled at   | Be               | 17. Father's Name (First, Middle, Last)   |  |  | 18. Mother's Na  | me (First, Middle, I                  | Maiden Sumame)                     | llier  |
| should<br>nd Mer<br>marke  | 10               | 19a. Informant's Name/Relationship (Type  | pe, Print)   | 19b. Mailing Address                           | s (Street and Number or R                                  | ural Route Number                     | City or Town, State,               | Zip Code)  |
| end 2<br>end 2<br>ealth a<br>n 27 is   |                  | Sheila A. FINI  | veY (granddaugh  | ter) 625                                       | Wellington   |                                       | alisburyin                         |  |
| ages 1<br>Intofficer in its interest   |                  | 20a. Method of Disposition  1 Burial 2 Cremation 3 Re   | emoval from State                                      | ace of Disposition (Na<br>metery, crematory or | other place)   |                                       | 20c. Location - dity or Westove    |  |
| mit. Popartme  |                  | 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Dicense  |  | CECIONIA N<br>22. Name a                       | nd Address of Facility                                     | 917 W.I                               | sabella St                         |  |
| Degree of the control |                  | MA  | 28)  | FUNE   | al Home  |                                       | yind 218                           |  |
|  |                  | 23a. Part1. Enter the disease, or complice shock, or heart faifure. List only on Immediate Cause (Final                           | e cause on each line.                                  |  | de of dying, such as cardia                                | c or respiratory arr                  | <i>e</i> st,                       | Approximate<br>Interval Between<br>Onset and Death |
| Physician<br>/Medical  |                  | Immediate Cause (Final disease or condition resulting in death)   | Due to (or as a consequence                            |  | •  |                                       |                                    |  |
| Examiner   |                  | Sequentially fist conditions, b   | DIABET 45  |  | MS.  |                                       |                                    |  |
| uted<br>d<br>ansit   | Examiner         | Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | H M  | ence or,                                       |  |                                       |                                    |  |
| cate be executed physician and the burial-transit  | i Exa            | resulting in death) Last  | Due to (or as a conseque                               | ence of):                                      |  |                                       |                                    |  |
| icate be e   | dicai            | <b>Q</b> d  |  |  |  |                                       |                                    |  |
| death certifine ettending i  | an/Me            | 23b. Was decedent pregnant  | 3c. If yes, outcome of pregnan                         |  | regnancy   |                                       | 23d. Date of de<br>Month           | ivery<br>Day Year                                  |
| wrequires that the death certifications is a second of the stending is should be detached for use as   | Physician/Me     | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 4☐Pregnant at time of de<br>9☐ Unknown                 |  |  |                                       | WORT                               | Day 1 bai  |
| requires thet the seen signed by the hould be detached   | by Ph            | Part II. Other significant conditions con   | tributing to death but not resul                       | Iting in the underlying                        | cause given in Part I.                                     | 23e. Did to                           | bacco use contribute to            | \ a  |
| HECOLOS  ne law requires thas been signate and be  |                  |   |  |  |  | -                                     | es 2 □ No 3 □ P                    |  |
| e la has   | Completed        |   |  |  |  | 24a. Was a<br>autop<br>perfor         | med?   death?                      | utopsy findings available completion of cause of   |
| VICAL P<br>NICIAN: Th<br>Certificate<br>rector, pag  | Be Co            | 25. Was case referred to medicat examiner?  |  |  |  | 1 ☐ Yes<br>eath (Check only or        |                                    | 2 140  |
| Or VICA Physician: this certific ral director,   | ို               | 1 Yes 2 Ho  |  | ER/Outpatient 3 D                              |  |                                       | ence 6 Other (Spe                  | cify)  |
| VISION ( Attending For death.  ector: After by the funer   | ation            | 1 Naturaf 5 Pending 2 Accident investigation  | (Month, Day Year)                                      | Injury M                                       | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No                  | 250. 5000,120 1.                      | ow injury occurred                 |  |
| JIVISION OF Attending after death. Director: Afte  | Certification:   | 3 Suicide 6 Could not be determined   | 28e. Ptace of Injury - At hor building, etc. (Specify, | me, farm, street, facto                        | ry, office   | 28f. Location (S<br>City or Tow       | treet and Number or R<br>n, State) | ural Route Number,                                 |
| DIVISION OF VICE  To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific Completely filled in by the funeral director,   | alCe             | 29a. Certifier Certifying Phys  | sician: To the best of my knov                         | wledge, death occurred                         | d at the time, date and place                              | e, and due to the o                   | ause(s) and manner a               | s stated.  |
| the Ho<br>hin 24<br>the Fu   | Medical          | one)  | ner: On the basis of examinati<br>and manner stated.   |  | ec. License number   |                                       | 29d. Date signed (Mon              |  |
| o i i c  |                  | 29b. Signature and title of certifier   |  | 2  | D63433   |                                       | 72717                              | ,, ==-,  |
| 2111   |                  | 30. Name and address of person who co   | 100 / 1011   | 23a) (Type, Print)                             | Hanlin.  | SAUSI                                 | 24101/10                           | Oloali   |
|  | tate             | 31. Date fifed (Month, Pay, Year)   | 32. Bygistrar's Signat                                 | lure   | 17 704 15  | SMUSI                                 | DURY MD                            | 21814  |
| Regis  |                  | AUG 0 1 2   | JU/ Reases   | H. Sonath                                      | ,  |                                       |                                    |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 7:00 PM JUI 30,2007 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 591 Str 0 15bUR omic If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Hours Days 231-70-196 1 M 2 F -14 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a, State 10b. County or 28e-f ahow the Medical Examiner must be notified at Yes 2 No SOURY comic Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ON Items 23a Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. ont: If item 27 is marked other than "naturel", or Items 23 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?...
1 Yes 2 No If Yes Give 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No 21215-0036 Specify: Specify. 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) erdue Farms College (1-4or 5+) Elementary/Secondary (0-12) roning 6 roduction Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Kennedi traumatic ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 3 3 anc 0 other 1 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition

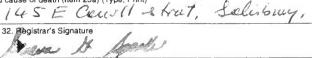
1 Seurial 2 Cremation 3 Removal from State 5 permit. Page Department o importent: If eny injury or HAmpton Mem, Gar. 5 Other (Specify) 22. Name and Address of Facility Pocomoke, 21. Sign ra of Runeral Service Licenses UNETAL Home Bennie Smith md 21851 819 FOURTH ST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tenure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Corcinoma monto **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any beauty to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) P.O. | detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ director, page 2 should be 3 Probably 4 Donknown 1 □ Yes 2 □ No. Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 1 No 2 🗆 No 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA Certification: To funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 27. Manner of Death 28b. Time of After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗍 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2007 D0014314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)
AUG 0 1 2007

PANPIT

P. KLUG



MD. 2180

| _            |  |                | 1 = For<br>State<br>Registrar   |   | Marylan                             |                                | artment<br>rtificate                       |                    |                            | and Me                     | ental Hyg                                   | iene                             | 17                               | 20253                                     |
|--------------|--|----------------|---|---|-------------------------------------|--------------------------------|--|--------------------|----------------------------|----------------------------|---|----------------------------------|----------------------------------|---|
| П            | Physici  | an             | Decedent's Name (First, Middle  | a, Last)  |                                     |                                |  |                    |                            |                            | <ol><li>Date of Deat<br/>Month</li></ol>    | h<br>Day                         | Yeer                             | 3. Time of Death                          |
|              | /Medic   |                | Harrol  |   | erson                               |                                |  |                    |                            |                            | Zuly  | 29, 2                            | 007                              | 13,40 M                                   |
| 1            | Examin   | er             | 4a. Facility Name (If not institution   |   | oer)                                |                                |  |                    | Location o                 |                            |   | 4c. County                       |                                  | _   |
|              |  |                | 56 Ratledge I   |   | Ama /In ura i                       | and histhdays                  | If Under                                   |                    | wingo                      |                            | 0. Data of Righ                             | 1                                | Ceci                             |   |
|              | Funeral<br>Director  |                | 462-64-1538   | 1 M 2 F   | Age (In yrs. I                      | Yrs.                           | Months                                     | Days               | Hours                      | Min.                       | 8. Date of Birth<br>(Month, Day,<br>une 30, | Year)                            | Cou                              | olace (State or Foreign<br>ntry)<br>Texas |
|              |  |                | Usual Residence of Decedent   |   | 04                                  |                                | LL   |                    |                            |                            | une 50,                                     | 1743                             |                                  | Texas                                     |
|              | yland  |                | 10a. State 10b. County  |   | 10c. City                           | , Town or Lo                   | cation                                     |                    |                            |                            | -   |                                  | -                                | 10d. Inside City Limits                   |
|              | Marfel   | tor            | Maryland Ce   | cil   |                                     |                                |  | Conc               | wingo                      | 0                          |   |                                  |                                  | 1 ☐ Yes 2 🔀 No                            |
|              | or 28  | Director       | 10e. Street and Number  |   |                                     |                                | 10f. Zip (                                 |                    |                            |                            | 1   | 0g. Citizen of \                 | What Cou                         | ntry?                                     |
|              | 1th wi   | J le           | 56 Ratledge   | Lane  |                                     |                                |  |                    | 2191                       | 18                         |   |                                  | U.S                              | S.A.                                      |
|              | 72 hours after death with the Maryland<br>Instural', or Hams 23s or 28s-f show<br>disel Exaculate must be collified at   | by Funeral     | 11. Marital Status  | 12. Was Decedo  | es?                                 | S. 13.                         | Was Decede                                 | ent of His         | spanic Orig                | gin? (Spec<br>, Puerto R   | cify Yes or No-<br>lican, etc.)             |                                  | e - Americk, White,              | can Indian,<br>etc.                       |
| 36           | s afte   | Ϋ́F            | 1 Never Married 2 Marri   | If Yes, Give  |                                     |                                | 1 ☐ Yes 2                                  |                    | Specify:                   |                            |   | Specif                           | ν: <b>τ</b> ν                    | White                                     |
| 21215-0036   | hour<br>tural  | d b            | 3 Widowed 4 Divorced  |   | es: 1960 <b>-</b>                   |                                | danta Have                                 |                    | tion                       | <del> </del>               |   | 16b. Kind of B                   |                                  |   |
| <u>수</u>     | n 72<br>"na"   | Completed      | (Specify only highes  | t grade completed)  |                                     | (Give                          | dent's Usual<br>kind of worl<br>DO NOT use | k done d           | uring most                 | t of working               | g   | TOD. KING OF B                   | usiness/in                       | dustry                                    |
| 7            | with<br>lene.<br>thar  | Juc.           | Elementary/Secondary (0-12) Twelve Years  | College (1-4  | or 5+)                              |                                | Staff                                      |                    |                            | •                          |   | U.S. A                           | cmsz                             |   |
| D            | Hyg<br>other<br>ent,   | Be C           | 17. Father's Name (First, Middle,   | Last)   |                                     |                                |  | 7                  |                            |                            | (First, Middle, I                           |                                  |                                  |   |
| <u>a</u>     | lid be<br>lenta<br>ked<br>ked<br>ic av   | To B           | Marvin  | Roberson  |                                     |                                |  |                    |                            | Murt                       | le Whit                                     | Α                                |                                  |   |
| Maryland     | shou<br>ind N<br>s mar<br>umat   | _              | 19a. Informant's Name/Relations   |   |                                     | 19b. Mailir                    | ng Address                                 | (Street a          | nd Numbe                   |                            | Route Number                                |                                  | State, Zip                       | Code)                                     |
| Ž            | alth a 27 ls   |                | Mary Jean Rober   | son (wife)  |                                     | 56 Ra                          | tledg                                      | e La               | ne, C                      | Conow                      | ingo, M                                     | aryland                          | d 21                             | .918                                      |
| J.C          | of He<br>item  |                | 20a. Method of Disposition  | - 77  |                                     | lace of Dispo                  | sition (Nam                                | e of<br>her place  | )                          | Da                         | ate   | 20c. Location -                  | City or To                       | own, State                                |
| Ĕ            | Page<br>ment<br>ant: If<br>arry or   |                | 1 ☑ Burial 2 ☐ Cremation<br>`4 ☐ Donation 5 ☐ Other (S)   |   | ale                                 | t Nottir                       |  |                    | - 1                        | 08/02                      | 2/07  | Colora,                          | Mar                              | yland                                     |
| Baltimore,   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic avent, the Medical Esan are must be publiced at once. |                | 21. Sign Jure of Funeral Service  | Licersee  | m.s                                 |                                | Name and                                   |                    |                            |                            | on Fune<br>21903                            | eral Ho                          | me, I                            | P.A.                                      |
|              |  |                | 23a. Part1. Enter the disease, or   | complications that cau                                      | sed the death                       |                                |  |                    |                            |                            |   |                                  |                                  | Approximate<br>Interval Between           |
| 1            | Physician  |                | shock, or heart failure. List<br>Immediate Cause (Final   | only one cause on eac                                       | m iine.                             | -                              |  |                    |                            |                            |   |                                  |                                  | Onset and Death                           |
|              | /Medical   |                | disease or condition resulting in death)  | Due to (or  | as a cons                           | ience of):                     | ncy  |                    |                            |                            |   |                                  | -                                | years                                     |
|              | Examiner   |                | December 15 to 15 | b   |                                     |                                |  |                    |                            |                            |   |                                  |                                  |   |
|              | D =  | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  |   | as a consequ                        | ience of):                     |  |                    |                            |                            |   |                                  |                                  |   |
|              | ecute<br>ind<br>trans  | Examiner       | cause. Enter Underlying<br>that initiated events<br>resulting in death) Last  | c   |                                     |                                |  |                    |                            |                            |   |                                  |                                  |   |
| 90,          | cate be executed physician and the burial-transit  | Ê              | rosoning in doutry East   | Due to (or  | as a consequ                        | ience of):                     |  |                    |                            |                            |   |                                  |                                  |   |
|              | physic   | dical          |   | d   |                                     |                                |  |                    |                            |                            |   |                                  |                                  |   |
| 9 X          | death certifica<br>e attending ph<br>id for use as t   | Physician/Me   | IF FEMALE:  | 23c. If yes, outco  | me of pregnar                       | ncv                            |  |                    |                            |                            |   | and De                           | en në dhelisu                    |   |
| Вох          | atten<br>for u   | clan           | 23b. Was decedent pregnant in the past 12 months?   | 1 Live birt   | h 2 ∏ Fetal<br>nt at time of de     | death 3                        | Ectopic pre Other (spe                     |                    |                            |                            |   |                                  | te of delive<br>onth             | Day Year                                  |
| P.O.         | 0 0 2  | iysic          | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9□ Unknow   |                                     | Juli 5_                        | 1 Ottier (ape                              |                    |                            |                            |   |                                  |                                  |   |
|              | The law requires that the death cer<br>lite has been signed by the attendir<br>age 2 should be detached for use  |                | Part II. Other significant condition  | ons contributing to dea                                     | th but not resu                     | ılting in the u                | nderlying ca                               | use give           | n in Part I.               |                            | 23e. Did tob                                | acco use cont                    | ribute to t                      | he cause of death?                        |
| rds,         | quires<br>n sign   | d by           |   |   |                                     |                                |  |                    |                            |                            | 1 □ Ye                                      | s 2 □ No                         | 3 🗌 Prot                         | pably 4 Unknown                           |
| Vital Record | w requir<br>s been si<br>should  | Completed      |   |   |                                     |                                |  |                    |                            |                            | 24a. Was a                                  | n 24b.                           | Were auto                        | opsy findings available                   |
| æ            | he lav<br>e has<br>age 2   | mo             |   |   |                                     |                                |  |                    |                            |                            | autops                                      | ned?                             | prior to co<br>death?<br>1 □ Yes | impletion of cause of                     |
| a            | an:<br>tifical<br>tor, p   | a              | 25. Was case referred to medical  |   |                                     |                                |  |                    | 26 Place                   | of Death                   | 1 ☐ Yes 2<br>(Check only on                 |                                  | 1 1 105                          | 2010                                      |
| <u> </u>     | Physician:<br>this certifice<br>ral director,  | ,0<br>B        | examiner?<br>1 Tes 2 No   | Hospital:   | patient 2 1                         | ER/Outpatien                   | nt 3□ DO/                                  | Othe               | r                          |                            | e 5 X Reside                                |                                  | er (Specif                       | (v)                                       |
| 0            | g Ph   | n: T           | 27. Manner of Death   | 28a. Date of  |                                     | 28b. Time of                   |  | Bc. Injury<br>Work |                            |                            | 3d. Describe ho                             |                                  |                                  | ,   |
| jo           | Attending or death. sector: After by the fune  | atlo           | 1 Natural 5 Pending investig  | gation  | July 104.7                          | ,u.y                           | М  |                    | es 2 🗆 N                   | No                         |   |                                  |                                  |   |
| Division of  | al or Atter<br>after de<br>Directo<br>d in by th   | Certification: | 3 ☐ Suicide 6 ☐ Could r<br>4 ☐ Homicide determ  | ined 286. Place of  | f Injury - At ho<br>, etc. (Specify | me, farm, str                  | eet, factory,                              | office             |                            | 28                         | Bf. Location (St.<br>City or Town           |                                  | er or Rura                       | al Route Number,                          |
|              | To the Hospital or Attending Physician: The I within 2 House after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.   | edical C       | 29a. Certifier 1 Certifyin (Check only 2 Medical l  | g Physician: To the be<br>Examiner: On the bas<br>and manne | is of examinat                      | wledge, death<br>ion and/or in | n occurred a vestigation,                  | it the time        | e, date and<br>inion, deat | d place, ar<br>th occurred | nd due to the ca                            | ause(s) and ma<br>ate and place, | anner as s<br>and due to         | stated.<br>the cause(s)                   |
|              | To the within 2 To the complet   | Me             | 29b. Signature and title of certifier   | /   |                                     |                                | 29c.                                       | License            | number                     |                            | 2   | 9d. Date signe                   | d (Month,                        | Day, Year)                                |
| )            | - > - 0  |                | NA FORM   | as Mo   |                                     |                                | 1  | 7/4                | 13/                        | 14                         |   | 3 mls 3                          | 30. 2                            | 007                                       |
| 2            | 0.70   |                | 30. Name and address of person  | who completed cause   | of death (Item                      | 23а) (Туре.                    | Print)                                     |                    | _//                        |                            | -   | to the                           |                                  |   |
| ٥٩           | - IVA  |                | H Furkes  |   |                                     |                                | , /33                                      | 3 N                | Br.                        | Lac                        | St. 54                                      | 1/2 5                            | E,                               | 007<br>lktm 119                           |
|              | Sta<br>Registr   |                | AUG 1 200   | 7 Beeck   | ns Ho<br>pistrar's Signat           | Speed                          |  |                    |                            | /                          |   |                                  |                                  |   |

|                          |  |                | 1 - For State Registrar  | State of M  | aryland         |                             | artment of H<br><i>tificate of L</i>                      |   |   | giene<br>Reg. No.          |   |                                      |
|--------------------------|--|----------------|--|---|-----------------|-----------------------------|---|---|---|----------------------------|---|--------------------------------------|
|                          | Physici  | an             | Decedent's Name (First, Middle  Vinn  A  |   |                 |                             |   |   | 2. Date of Dea                            | Day                        | Year  | 3. Time of Death                     |
|                          | /Media   | cal            | Kim A.  4a. Facility Neme (If not institution,   | Robey   | 1               |                             | 4b. City, Town, or  | Location of Doot                                  | July                                      | 29                         | 2007<br>ounty of Death                          | 12:00P M                             |
|                          | Examir   | ier            | 5950 Smallwood   | Church Roa  |                 |                             | Indian  |   | 11  |                            | Charles   |                                      |
| *                        | Funeral<br>Director  |                | 5. Social Security Number 249-47-3712  |   | ge (In yrs. las | st birthday)<br>Yrs.        | If Under 1 Year<br>Months Days                            | If Under 24 Hrs Hours Min.                        |   | , 1964                     | 9. Birthpi<br>Coun                              | lace (State or Foreign<br>try)<br>SC |
|                          | land ow  |                | Usual Residence of Decedent 10a. State 10b. County   |   | 10c. City,      | Town or Lo                  | cation  |   |   |                            | 10  | Od. Inside City Limits               |
|                          | Mary<br>Ff sh  | to             | MD Ch.   | arles   |                 | Ind                         | ian Head  |   |   |                            |   | 1 ☐ Yes 2Ã No                        |
|                          | or 28;   | Director       | 10e. Street and Number   |   |                 | -                           | 10f. Zip Code   |   |   | -                          | n of What Coun                                  | try?                                 |
|                          | s 23a  |                | 5950 Smallwood   | Church Road   |                 | 10.1                        | 20640   |   |   | US                         |   | and India                            |
| 336                      | permit. Pages 1 and 2 should be filed within 72 hours after death with fhe Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examinations is notified at once. | by Funeral     | 11. Marital Status  1 Never Married 3 Married 3 Widowed 4 Divorced   | Armed Forces?   | ?               |                             | Vas Decedent of His<br>f Yes, specify Cubar<br>□ Yes 2☐No | Spanic Origin? (S<br>n, Mexican, Puer<br>Specify: | to Rican, etc.)                           |                            | Race - Americ<br>Black, White, o<br>Pecify: Whi | etc.                                 |
| 5-0                      | 72 hou   |                | 15. Decedent'<br>(Specify only highes  | s Education   |                 | 16a. Deced                  | lent's Usual Occupa<br>kind of work done di               | tion  | dkina                                     | 16b. Kind                  | of Business/Ind                                 | lustry                               |
| Maryland 21215-0036      | within<br>one.<br>than "   | Completed      | Elementary/Secondary (0-12)  | College (1-4or  | 5+)             | life. L                     | oo NOT use retired)<br>Fice Mana                          |   | i king                                    | D                          | ental   |                                      |
| 9                        | Hygie<br>Other<br>ent, II  |                | 17. Father's Name (First, Middle, L  | ast)  |                 |                             | · · · · · · · · · · · · · · · · · · ·                     |   | ne (First, Middle,                        |                            |   |                                      |
| ılan                     | uid be<br>Mental<br>irkad<br>itic av   | To Be          | Robert Daley   |   |                 |                             |   | Gertr   | ude Dale                                  | У                          |   |                                      |
| fan)                     | 2 sho<br>and 1<br>Is ma  |                | 19a. Informant's Name/Relationsh   |   |                 |                             | g Address (Street a                                       |   |   |                            |   |                                      |
| e,                       | 1 and<br>Health<br>em 27<br>thar t   |                | Christopher Robe   | ey/Husband  |                 |                             | Smallwood sition (Name of                                 | Church  | Road, Ind                                 |                            | ead, MD   |                                      |
| TOL                      | ages<br>ant of<br>nt: If It<br>y or o  |                | f Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Sp   |   | cen             | netery, cren                | natory or other place                                     |   |   |                            |   |                                      |
| Baltimore,               | permit. F<br>Departm<br>Importar<br>any injui  |                | 21. Signature of Funeral Service L   |   | 00945           |                             | am Cemeter Name and Address AREHART—E(                    |   |   |                            | 1des,Ma   |                                      |
|                          | av5 **   |                | 23a. Part1. Enter the disease, or  | complications that caused   | d the death.    | Do not enti                 | or the mode of dying                                      | , such as cardiad                                 | e LaPla<br>or respiratory ar              | ta, MD                     | 20646   | Approximate                          |
| 1                        | Physician<br>/Medical  |                | shock, or heart failure. List of<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | a. Due to (or as  | MI              | nce of):                    | CA  | UCEN  | <u>).</u>                                 |                            | >   | Onset and Death                      |
| ij                       | Examiner   | <u></u>        | Sequentially list conditions,  | b   |                 |                             |   |   |   |                            |   |                                      |
|                          | uted<br>1  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or as   | a conseque      | nca or).                    |   |   |   |                            |   |                                      |
| Ö,                       | ificate be executed<br>g physicien and<br>as the burial-transit  |                | that initiated events<br>resulting in death) Last  | C. Due to (or as  | a consequer     | nce of):                    |   |   |   |                            |   |                                      |
| 68760,                   | cate be  | edical         |  | d   |                 |                             |   |   |   |                            |   |                                      |
| Вох                      | The law requires that the death certificate has been signed by the attending prage 2 should be detached for use as   | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant al                 | 2 Fetal de      | eath 3 🗆                    | Ectopic pregnancy<br>Other (specify)                      |   |   | 23d.                       | . Date of deliver<br>Month                      | ry<br>Day Year                       |
| ds, P.O.                 | ires that the signed by the detact   | by             | Part II. Other significant condition   | s contributing to death b   | out not resulti | ng in the ur                | derlying cause giver                                      | n in Part I.                                      |   |                            |   | e cause of death?                    |
| 200                      | v requ<br>been<br>should   | etec           |  |   | **              |                             |   |   | 24a. Was a                                |                            |   | psy findings available               |
| Division of Vital Record | n: The lav<br>ficate has<br>n, page 2  | e Completed    | OF West and the state of the st |   |                 |                             |   |   | autop<br>perfor<br>1 ☐ Yes                | med?<br>2  No              | prior to com<br>death?                          | apletion of cause of                 |
| $\equiv$                 | ysicia<br>s certi  | OB             | 25. Was case referred to medical examiner?  1 Yes 2 No   | Hospital:   | ent 2 EP        | VOutpatient                 | Othor   |   | ome Tr Resid                              | 1                          | Other (Specify                                  | 1)                                   |
| o uo                     | Attending Physician: r death. ector: After this certifici<br>by the funeral director.  | tion: T        | 27. Manner of Death 1 2 Natural 5 Pending 2 Accident Investigation   | 28a. Date of Inju<br>(Month, Da                                     | ry 28           | 8b. Time of<br>Injury       | 28c. Injury<br>Work                                       |   | 28d. Describe h                           |                            |   |                                      |
| Divisi                   | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2   | Certification: | 3 Suicide 6 Could no<br>4 Homicide determin  | ot be One Bloss of Inc  |                 | e, farm, stre               | et, factory, office                                       |   | 28f. Location (S<br>City or Tow           |                            | umber or Rural                                  | Route Number,                        |
|                          | To the Hospital or within 24 hours afte To the Funeral Director completely filled in I   | edical         | 29a. Certifier Check only one) Certifying 2 Medical E  | Physician: To the best<br>xeminer: On the basis o<br>and manner sta | f examination   | edge, death<br>n and/or inv | occurred at the time<br>estigation, in my opi             | e, date and place<br>nion, death occu             | , and due to the c<br>rred at the time, c | ause(s) and<br>ate and pla | d manner as sta                                 | ited.<br>the cause(s)                |
| i                        | To the within 2 To the complet   | Me             | 29b. Signature and title of certifier  | [Del  | Im              | N                           | 29c. License  | 20 E  | 24  | 9d. Date si                | gned (Month, C                                  | Pay, Year)                           |
| 5                        | 06 IX  |                | 30. Name and address of person w   | the completed cause of d  | leath (Item 2:  | 3a) (Type, f                | Print) D \N   | AUD   | 012 EV                                    | no                         | 206   | 03                                   |
| Ī                        | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year) AUG ()   | 32. Registr   | ar's Signatur   | × 1                         | naste   |   |   |                            |   |                                      |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Mildred Giles Rowland 10:50 PM 2007 Julv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LaCasa Assisted Living Annapolis Anne Arundel 5. Social Security Number 7. Age (In vrs. last hirthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 16, 1916 North Carolina 1 🗌 M June Director 237-18-5229 91 Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits 10h Counts item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1∏Yes 2□No **Funeral Director** Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 93 Quarter Landing Road 21403 United States 12. Was Decedent Ever in U.S. Armed Forces?v 1 Tyes 2 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify Completed by Specify: White ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) Civil Service U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nathaniel Giles Addee Lee Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James L. Myers / Nephew item 27 i 93 Quarter Landing Rd. Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ☐ Burial XXCremation 3 ☐ Removal from State 7/27/2007 Baltimore, Maryland Baltimore Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home. Inc. 21. Signature of Funeral Service Lice 147 Duke of Gloucester St. Annapolis, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ntractable Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner zheime Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical Not applicable 23d. Date of delivery IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an ate has bage 2 s autopsy performed? Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be ssister 2 No Other: 4 Nursing Home 5 Residence 1 🗀 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) funeral 27. Manuar of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 5 Pending investigation ours after death.
neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

State Registrar 31. Date filed (Month, Day, Year) 3 0 2007

ROMER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

29b. Signature and title of certifier



29c. License number

Highway Suite

29d. Date signed (Month, Day, Year)

|   |                 | Please Type or Print in Black State of Maryland / D  | Department of H  | Health and M                        |                                  | _                            | lible.   | () " () " "                                   |
|---|-----------------|--|--|-------------------------------------|----------------------------------|------------------------------|--|---|
| Physicia  | an              | Registrar  1. Decedent's Name (First, Middle, Last)  WALTER  | Certificate of RANKIN  | Death                               | 2. Date of Dea                   | ith 26                       | 0 <sup>Year</sup>                                | 3. Time of Death 4:10 A M                     |
| /Medic<br>Examin  |                 | 4a. Facility Name (If not institution, give street and number) WMHS-BRADDOCK CAMPUS  |  | or Location of Death                |                                  | 4c. Coun                     | ty of Death                                      |   |
| Funeral<br>Director   |                 | 5. Social Security Number 6. Sex. 7. Age (In yrs. last bird 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  |  | If Under 24 Hrs. Hours Min.         | 8. Date of Birth<br>(Month, Day  | n<br>v, Year)                | 9. Birthp  | place (State or Foreign                       |
| f show  | or              | Usual Residence of Decedent           10a. State         10b. County         10c. City, Town           Maryland         Allegany         Eckhart   |  |                                     |                                  |                              | 1  | l0d. Inside City Limits 1 Mayes 2 □ No        |
| with the Na or 28a-t  | Director        | Maryland Allegany Eckhart  10e. Street and Number 1603 Laurel Hill S.W.  | 10f. Zip Code  |                                     |                                  | 10g. Citizen o               | f What Cour                                      | ntry?   |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dispartment of Health and Mental Hygiene.  Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | d by Funeral    | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☑ Yes 2 □ No If Yes, Give Year or Dates: WW II.  | 21528- 13. Was Decedent of Hif Yes, specify Cub 1 Yes 2 No                   | Specify:                            | ecify Yes or No-<br>Rican, etc.) | Spec                         | Whit   | etc.  |
| ithin 72 h<br>ne.<br>nan "natu  | Completed       | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)   | Decedent's Usual Occup<br>(Give kind of work done<br>life. DO NOT use retire | pation<br>during most of work<br>d) | ing                              | 16b. Kind of                 |  |   |
| be filed w<br>tal Hygiel<br>d other th  | Be Cor          | 17. Father's Name (First, Middle, Last)  | echanic  | 18. Mother's Name                   |                                  | state roa<br>Maiden Surna    |  | rtment  |
| should Ind Men<br>marke<br>matic  | ဍ               | Clayton Rankin  19a. Informant's Name/Relationship (Type, Print)  19b  | . Mailing Address (Street  | Margaret C                          |                                  | er. Citv or Tow              | n. State. Zir                                    | Code)   |
| and 2 sealth ar   |                 |  | 603 Laurel Hill. S.  |                                     | Eckhart                          |                              | yland  | 21528-  |
| iges 1 and of He  |                 | 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State cemeter   | f Disposition (Name of<br>ry, crematory or other pla                         | ice)                                | Date                             | 20c. Location                | •  |   |
| nit. Pa<br>vartmer<br>ortant<br>Injury<br>e.  |                 | 4 □ Donation 5 □ Other (Specify) Cumber  21. Signature of Euneral Service Licenses   | rland Crematory  22. Name and Addre  |                                     | y 26, 2007                       | Cumberl                      | and Ma   | ryland  |
| permi<br>Depa<br>Impo<br>any Ir   |                 | John R. Wurt   | Durst Funer  | ral Home, 57 I                      | Frost Ave.,                      | Frostburg                    | g, MD 2  | 21532   |
| Physician<br>/Medical<br>Examiner   | er              | Due to (or as a consequence of   | OBSTRUC  |                                     |                                  |                              | as   | Approximate Interval Between Onset and Death  |
| ficate be executed physician and s the burial-transit   | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen | of):   |                                     |                                  |                              |  |   |
| The law requires that the death certificate are has been signed by the attending physoage 2 should be detached for use as the   | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  | n 3 ⊟Ectopic pregnanc<br>5 ⊡ Other (specify) _                               | y                                   |                                  |                              | ate of deliv                                     | ery<br>Day Year                               |
| uires that<br>signed by<br>d be deta  | þ               | Part II. Other significant conditions contributing to death but not resulting in   | n the underlying cause given DISEAU2   | ven in Part I.                      |                                  | obacco use co<br>′es 2 □ No  |  | he cause of death?                            |
| ate T   | Completed       | CUNGESTIVE HEART PAIL  | LURE   |                                     | 24a. Was autop                   |                              | o. Were auto<br>prior to co<br>death?<br>1 □ Yes | opsy findings available impletion of cause of |
| sician: Th<br>certificate<br>rector, pag  | Be              | 25. Was case referred to medical examiner?  Hospital: Hospital:  | trationt 3D DOA Oth  | 26. Place of Deat                   |                                  |                              |  |   |
| To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, I   | ation: To       | 27. Manner of Death  1 Natural 5 Pending 2 Accident Accident Accident 2 Sa. Date of Injury (Month, Day Year)   | Time of lnjury 28c. Inju   | 4 □ Nursing Ho                      | ome 5 Residence Residence Page 1 |                              |  | fy)   |
| tal or Atte<br>s after de<br>al Directo   | Certification:  | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, fa building, etc. (Specify)  | erm, street, factory, office   |                                     | 28f. Location (S<br>City or Tow  | Street and Nur<br>vn, State) | nber or Run                                      | al Route Number,                              |
| he Hospit<br>in 24 hour<br>he Funera<br>pletely fille   | edical          | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge and Medical Examiner: On the basis of examination an and manner stated.   |  |                                     |                                  |                              |  |   |
| 4/10A   | Σ               | 29b. Signature and title of certifier  | 29c. Licens  | se number                           |                                  | 29d. Date sign               |  | Day, Year)                                    |
| MRS   |                 | 30. Name and address of person who completed cause of death (Item 23a) ( DR · HARTI+ SIGHU 935 BISH  | (Type, Print)  |                                     | Cumi                             | berlan                       | nd, m  | D 21502                                       |
| Sta<br>Registr  |                 | 31. Date filed (Month, Day, Year)  JUL 2 7 2007  32 registrar's Signature  | Sparte   |                                     |                                  |                              |  |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Rantolfi Donald John July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS-Braddock Campus Cumberland 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/27/1938 7. Age (In yrs. last birthday) **Funeral** Months Hours Days Min. 1 M 2 □ F 276-34-0200 68 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f show edical Examiner must be notified at WV Ridgeley Director Mineral 10e. Street and Number 10f. Zip Code RR 4 Box 170-H (Plum Run Road) 26753 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 17 Yes 2 No 1960— If Yes, Give Year or Dates: 1967 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Completed by 3 ₩ Widowed 4 Divorced 1967 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 7
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Media once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Customer Service Representative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Rantolfi 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen B. Sines / Friend 13101 Gramlich Road, LaVale, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Cumberland Crematory: 07/20/2007 5 Other (Specify) 4 □ Donation 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock /Medical Due to (or as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Dehydration Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the a page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. ģ Completed 24a. Was an autopsy performed? Yes 2 X No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 X inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation Injury 1 XNatural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical fination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc White 16b. Kind of Business/Industry Tire and Rubber Petruzzi 20c. Location - City or Town, State Cumberland, MD Approximate Interval Between Onset and Death 10 days 10 days 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 M Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes

29d. Date signed (Month, Day, Year)

July 19, 2007

2 No

3. Time of Death

Birthplace (State or Foreign Country)

Ohio

3:15 A M

Day

2007

4c. County of Death

Allegany

10/1UA

State Registrar

31. Date filed (Month, Day, Year) JUL 2 0 2007

Qamar U. Zaman,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

M.D., 625 Kent Avenue, Cumberland, Maryland 32. Registrar's Signature

29c. License number

D23371

|   |                   | 1 - State Anend Items 23al Registrar  1. Decedent's Name (First, Middle, Las   | it)   |                                |                                |                        |                    |                                      | 2. Date                            |                                  | D                         |                                     | 3. Time of D                                |  |
|---|-------------------|--|---|--------------------------------|--------------------------------|------------------------|--------------------|--------------------------------------|------------------------------------|----------------------------------|---------------------------|-------------------------------------|---|--|
| Physici<br>/Medio   |                   | Joyce Web  | ster Sigr   | ist                            |                                |                        |                    |                                      | July                               | 28,                              | <sup>Day</sup> 2007       | Year                                | 10:15                                       |  |
| Examir  |                   | 4a. Facility Name (If not institution, give  |   | 7)                             |                                |                        |                    | Location of De                       | ath                                |                                  | 4c. Count                 |                                     |   |  |
|   |                   | 7790 Hayward Roa   |   |                                |                                |                        |                    | City                                 |                                    |                                  |                           | erset                               |   |  |
| Funeral Director  |                   | 5. Social Security Number 6. Sec. 11 219–14–4409   | M 2 A F 7. A  | .ge ( <i>in yrs. i</i><br>82   | a <i>st birthday)</i><br>Yrs.  | If Under<br>Months     | Days               | If Under 24 H<br>Hours M             |                                    | of Birth<br>h, Day, Y<br>2 / 1 O | ear)                      | Coul                                | olace <i>(State or i</i><br>ntry)<br>7 Land |  |
|   |                   | Usual Residence of Decedent  |   | 02                             |                                | l                      |                    |                                      | 07/1                               | 2/1/                             | -                         | 11aly                               | Land  |  |
| show<br>Tel   |                   | 10a. State 10b. County   |   | 10c. City                      | , Town or Lo                   | cation                 |                    |                                      |                                    |                                  |                           | 1                                   | 10d. Inside City                            |  |
| Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or items 23e or 28e-f show eny injury or other treumatic event, the Medical Exercities must be notified at once. | Scto              | MD Somerse   | t   | P                              | ocomok                         |                        |                    |                                      |                                    |                                  |                           |                                     | 1 🗌 Yes 2                                   |  |
| ben ten   | Funerai Director  | 10e. Street and Number   | •   |                                |                                | 10f. Zip               |                    |                                      |                                    | 10g                              | . Citizen of              |                                     | ntry?                                       |  |
| 18 23<br>Lines  | erai              | 7790 Hayward Road  | 10 Was Decedes  | t Ever in III                  | 9 121                          |                        | 21851              |                                      | (Casaibi Vas                       | - No                             | . ,                       | SA                                  | can Indian,                                 |  |
| r Item  | F                 | 1 Never Married 2 Married  | Armed Forces  | ?                              | 1                              |                        |                    | spanic Origin?<br>n, Mexican, Pu     | erto Rican, etc                    | i.)                              |                           | ck, White,                          |   |  |
| 0.18  | þ                 | 3√ Widowed 4 Divorced  | If Yes, Give<br>Year or Dates:  |                                |                                | 1 ☐ Yes 2              | NO                 | Specify:                             |                                    |                                  | Specif                    | <sup>y:</sup> Whi                   | ite   |  |
| netu<br>Jical   | Completed         | 15. Decedent's Ed<br>(Specify only highest grad  | ucation<br>de completed)  |                                | 16a. Deced                     | dent's Usua            | Il Occupa          | ition                                | vodkina                            | 16                               | b. Kind of B              | usiness/In                          | dustry                                      |  |
| han.  | mpi               | Elementary/Secondary (0-12)  | College (1-4or  | 5+)                            |                                |                        | e retired          | uring most of w                      | 9                                  |                                  |                           |                                     |   |  |
| hygie<br>thert  | ပိ                | 12 17. Father's Name (First, Middle, Last)   | 4   |                                | Homen                          | aker                   |                    | 18. Mother's N                       | lama /First 84                     |                                  | Own H                     |                                     |   |  |
| ed of   | ) Be              | Percy Webster  |   |                                |                                |                        |                    |                                      | e Gordy                            |                                  | iden Sumar                | ne)                                 |   |  |
| mark<br>mark  | ဥ                 | 19a. Informant's Name/Relationship (T  | voe. Print)   |                                | 19h Mailir                     | na Address             | /Street a          | nd Number or                         |                                    |                                  | ity of Town               | State 7in                           | Codel                                       |  |
| 27 IS   |                   | Michael Sigrist/   |   |                                |                                |                        |                    | Road, Po                             |                                    |                                  |                           |                                     |   |  |
| item<br>item<br>othe  | 1                 | 20a. Method of Disposition   |   |                                | ace of Dispo                   | sition (Nam            | ne of              | n                                    | Date                               | 20                               | c. Location               | - City or To                        | own, State                                  |  |
| nt: If  |                   | #Burial 2 □ Cremation 3 □ I  * 4 □ Donation 5 □ Other (Specify)  **The Company of the Comp |   | 9                              | -                              | •                      |                    | ´ 1                                  | /03/200                            | 7 Po                             | comok                     | e Cit                               | v. MD                                       |  |
| Departr<br>Importa<br>eny inju<br>once.   |                   | '4 Donation 5 Other (Specify) Quinton Cemetery 08/03/2007 Pocomoke City,  Signature of Funeral Structure of Funeral Home   |   |                                |                                |                        |                    |                                      |                                    |                                  |                           |                                     |   |  |
| 2 5 8   |                   | JUNES & LIW  | Kew Ja  | M002                           | 45                             |                        | rune<br>Comar      | cot Av                               | ne<br>anno F                       | rinc                             | ACC A                     | nno                                 | MD 218                                      |  |
| sician and<br>burial-transit  | i Examiner        | Sequentially list conditions, if my leading to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | b. Due to (or as  |                                |                                |                        | (                  | set Ave                              | PROVED BY M                        | DICAL                            |                           |                                     |   |  |
| by the attending phy<br>tached for use as the   | Physician/Medicai | in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown  | d.<br>23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant a<br>9 □ Unknown | 2 Fetal                        | death 3 ath 5                  | Ectopic pre            | egnancy<br>ecify)  |                                      |                                    |                                  | 23d. Da                   | te of delive                        |   |  |
| gne<br>bed  | by                | Part II. Other significant conditions co<br>HYPERTENSIO  | W Perfor  | ated Br                        | rap Sta                        | ities Po               | et Al-             | n in Part I.<br><b>doninal</b>       |                                    |                                  | co use cont               |                                     | ne cause of dea<br>ably 4 ⊡Unl              |  |
| should  | Completed         | LORUNTRY A RIE   |   | Ens                            |                                | otic 1                 | Jem_               | nic                                  |                                    |                                  |                           |                                     |   |  |
| page 2  | duo               |  |   | C 7347                         | -                              |                        | 1000               | MARE                                 | á                                  | Mas an<br>iutopsy<br>erformed    |                           | Were auto<br>prior to cor<br>death? | psy findings ava<br>npletion of cau         |  |
| rtificate<br>stor, pa   |                   | 25. Was case referred to medical   | DUEL  | 3////                          | -17 10                         |                        | 500                | GERG                                 | 1 🗆 Y                              |                                  |                           |                                     | 2 No  |  |
| s ce<br>direc   | O B               | examiner?  | Hospital:<br>1 ☐ Inpatio  | ent 2∏F                        | R/Outpatien                    | 3 🗆 DO                 |                    | 26. Place of D                       |                                    |                                  | 6 🗆 Oth                   | or /Canait                          | -1  |  |
| 5 =   | ertification: T   | 27. Manner of Death  1. Natural 5 Pending 2 Accident investigation   | 28a. Date of Inju<br>(Month, Da   |                                | 28b. Time of<br>Injury         |                        | Bc. Injury<br>Work | at                                   |                                    |                                  | njury occuri              | er ( <i>Specif</i> y<br>red         | /)  |  |
| nerel Director:   | OL                | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | 28e. Place of In<br>building, et  | jury - At hor<br>tc. (Specify) | me, farm, stre                 | et, factory,           | office             |                                      |                                    | on (Stree<br>Town, S             |                           | er or Rura                          | l Route Numbe                               |  |
| - Fur   | edical            | 29a. Certifier 1 Certifying Phy check only one) 2 Medical Exami  | sician: To the best<br>ner: On the basis o<br>and manner st                   | it examinati                   | /ledge, death<br>on and/or inv | occurred a estigation, | it the time        | e, date and place<br>nion, death occ | ce, and due to<br>curred at the ti | the caus<br>me, date             | e(s) and ma<br>and place, | nner as st<br>and due to            | ated.<br>the cause(s)                       |  |
| To the complet  |                   | 29b. Signature and title of certifier  | 2   |                                |                                |                        | License            |                                      |                                    | 29d.                             | Date signe                |                                     | -   |  |
|   |                   | > Sprin  | > "   |                                |                                |                        | VOO                | 6291                                 | 6                                  | JM                               | (4 -                      | 30,                                 | 2007  |  |
|   |                   | 30. Name and address of person who co  |   |                                |                                |                        |                    |                                      |                                    | -                                |                           |                                     |   |  |

|                   |  |                     | FOI  | Certificate of Death  | Reg. No. 2 U C 7 2 0 2 0 .  |
|-------------------|--|---------------------|--|---|---|
|                   | Physicia   | an                  | 1. Decedent's Name (First, Middle, Last)   | Seddon 2. Date of E<br>Month  | Day Year  |
|                   | /Medic   | al                  | Phyllis  4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or Location of Death  | 28 2005) 11234 M  |
| 1                 | Examin   | ier                 | THE JOHNS HOPKINS HOSPITAR   | BALTINEORE CIT  |   |
|                   | Funeral  |                     | 5. Social Security Number 6. Sex 7. Age (In yrs. last birth  |   |   |
| E.                | Director   |                     | 138-24-0094  | rs. July  | 1,1930 New Jersey   |
|                   | land<br>ow   |                     | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  | or Location   | 10d. Inside City Limits   |
|                   | Mary<br>Fied a   | tor                 | Virginia Shenandoah Woods  | tock  | 1 ☐ Yes 2 💆 No  |
|                   | th the<br>or 28s   | Direc               | 10e. Street and Number   | 10f. Zip Code   | 10g. Citizen of What Country?   |
|                   | ath wi   | ral                 | 204 Kim Court  | 22664   | USA   |
| 21215-0036        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral Director | 11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:  | <ul> <li>13. Was Decedent of Hispanic Origin? (Specify Yes or Note of Not</li></ul> | 14. Race - American Indian, Black, White, etc.  Specify: White                |
| 5-0               | 72 hc<br>'natuı  | eted                | 15. Decedent's Education (Specify only highest grade completed)  | Decedent's Usual Occupation<br>Give kind of work done during most of working<br>life. DO NOT use retired)   | 16b. Kind of Business/Industry  |
| 121               | within<br>ene.<br>than "   | Completed           | Elementary/Secondary (0-12) College (1-4or 5+)   | Iffe. DO NOT use retired)  Homemaker  | Home  |
| d 2               | filed v<br>Hygie   |                     | 4 years  17. Father's Name (First, Middle, Last)   | 18. Mother's Name (First, Midd  |   |
| lan               | lental<br>fental<br>rked c   | To Be               | Harry S. Smith   | Hazel Harris  |   |
| Maryland          | 2 shou<br>and M<br>is mai  |                     | 19a. Informant's Name/Relationship (Type. Print) 19b.  | Mailing Address (Street and Number or Rural Route Num   | nber, City or Town, State, Zip Code)  |
| Σ,                | 1 and 2<br>Health<br>em 27 i   |                     | Dr. John W. Seddon/ Husband 20   | 4 Kim Court, Woodstock, VA  |   |
| Baltimore,        | permit. Pages 1 Department of H Important: If iter any Injury or ott   |                     | 20a. Method of Disposition  1 Burial 2 December 2  4 Donation 5 Other (Specify)  | Disposition (Name of community, crematory or other place)  Crematory 7-30-07  | 20c. Location - City or Town, State  Edgewater, MD                            |
| Balt              | permit. Departimont amy Inj  |                     | 21. Signature of Funeral Sept of Liverage  **DUCLIFF** CURLED  **D | 22. Name and Address of Facility George P<br>2973 Solomons Island Rd.   |   |
| Ü                 |  |                     | 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  | ot enter the mode of dying, such as cardiac or respiratory  | arrest, Approximate Interval Between  |
| i da              | Physician  |                     | Immediate Cause (Final disease or condition resulting in death)  |   | Onset and Death 7 days  |
|                   | /Medical<br>Examiner   |                     | Due to (or as a consequence o  | f):   |   |
|                   | A gr   | ler                 | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence o  | f):   |   |
|                   | cuted<br>nd<br>ransit  | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  |   |   |
| ,<br>00,          | tificate be executed<br>ig physician and<br>as the burial-transit  | I Ex                | resulting in death) Last  Due to (or as a consequence o  | ŋ:  |   |
| 68760,            | cate b   | Medical I           | d  |   |   |
|                   | certifi<br>ding p  | /Me                 | IF FEMALE: 23c. If yes, outcome pf pregnancy   |   | 23d. Date of delivery   |
| P.O. Box          | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit  | Physician/          | 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown  | 3 □Ectopic pregnancy 5 □ Other (specify)  | Month Day Year  |
|                   | es thai<br>gned t  | by P                | Part II. Other significant conditions contributing to death but not resulting in   | the underlying cause given in Part I. 23e. Did  | d tobacco use contribute to the cause of death?                               |
| ord               | w requir<br>been si<br>should I  | ted                 | Ascending Aortic Aneurysm  | 1   | ]Yes 2⊠ No 3  Probably 4  Unknown   |
| 3ec               | elaw<br>hasb<br>e2sh   | Completed           |  |   | topsy prior to completion of cause of   |
| a                 | n: Th<br>ficate<br>r, pag  |                     |  | 1□ Yes  |   |
| or Vital Records, | <b>hysician</b> : The law<br>his certificate has t<br>I director, page 2 s   | o Be                | 25. Was case referred to medical examiner?  1 ☐ Yes 2▼ No  Hospital: 1▼Inpatient 2 ☐ ER/Out  | 26. Place of Death (Check only patient 3 DOA Other:   |   |
| יסר               | ulng Phy<br>n.<br>After this<br>funeral c  | n: To               | 27. Manner of Death 28a. Date of Injury 28b. Ti  |   | e how injury occurred   |
| sior              | Attending r death. ector: After by the funer   | atio                | 2 Accident investigation   | M 1 Yes 2 No  |   |
| Division          | Il or Attend<br>after death.<br>I Director: A  | Certification:      | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, fan building, etc. (Specify)   | m, street, factory, office 28f. Location City or 7  | (Street and Number or Rural Route Number, own, State)                         |
|                   | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral   | Medical C           | 29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.  | death occurred at the time, date and place, and due to the time of      | ne cause(s) and manner as stated. ne, date and place, and due to the cause(s) |
|                   | Vithin Vithin To the Compl   | Me                  | 29b. Signature and title of certifier  | 29c, License number   | 29d. Date signed (Month, Day, Year)   |
|                   | all.   | 7                   | Physician  | RES-000   | July 28 2007  |
|                   | 1/1/20   |                     | 30. Name and address of person who completed cause of death (Item 23a) (7  |   |   |
|                   |  |                     | William Kostis Johns Hopkins Ho<br>31. Date filed (Month, Day, Year) 32. Bajistrar's Signature   | ospital 600 North Wolfe Street  | et Baltimore, MD 21287  |
|                   | Sta<br>Registi   |                     | JUL 3 1 2007   | breek s   |   |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Helen Virginia Trent 23, July 2007 9:40p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 14 Holly Road Severna Park Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 💢 F 217-18-9090 84 Director Mar 10, 1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at Anne Arundel Severna Park MD 1 ☐ Yes 2 No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21146 14 Holly Road USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 X Married 1 □ Yes 2X No Baltimore, Maryland 21215-0036 ρ Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Co-owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John C. Gillin Hester E. Hager 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Holly Road, Severna Park, Maryland 21146 Raymond Otis Trent/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) July 27, Glen Haven Memorial Park Glen Burnie, MD 2007 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Fyneral Service Licensee 23a. Part. Enter the disease, or collocations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 5 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. the attending physician hed for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 🗌 Yes Νo 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autops) perform 1∐ Yes 21 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home ome 5 Residence 6 □Other (Specify) 28d. Describe how injury occurred 2 ER/Outpatient 3 DOA P 1 Tes 1 🔲 Inpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Deatl Certification: After t To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

**JUL 27** 

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Month Year **Physician** FSOAM annon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Summit Convalescent Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 29 Director 524-53-6354 7/25/1978 NH Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Examiner must be notified at MD Anne Arundel Severna Park 1 ☐Yes Ž☐No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 109 Sherburn Rd. 21146 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must tonce. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 致致No Yes, Give 'ear or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes XX No Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond J. Evans Jr. Vickie Lyn Sullivan 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Archie Van Devender Jr. 109 Sherburn Rd. Severena Park, MD 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Magnolia Mem Gardens 8/1/2007 4 Donation 5 Dother (Specify) Hattiesburg, MS 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hardesty Funeral Home, P.A. Valret 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (Ar as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed sician and burial-tran physician the burial Division or Vital Records, P.O. Box 68760, Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f s been signed by should be detr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2**2** No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one Hospital: 1 Yes 25 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day Year) 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) uly 26, 2007 ddress of person who completed cause of death (Item 23a) (Type, Print) BOB 28 40 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 3 0 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene Linda Sue Vance 1. For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month Day July 31, 2007 1251 hrs Linda Sue VANCE **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington 202 E. Franklin Street, Apt. 3 Hagerstown 9. Birthplace (State or Foreign Washington 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 6. Sex 5. Social Security Number **Funeral** Months Days Hours Min Director Country) 18 1947 D.C. M 2X F 59 Nov. 218-50-3469 Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location in, s 23a or 28a-f show a notified at once. 1 X Yes 2 No Hagerstown Maryland Washington Director 10g. Citizen of What Country 10e, Street and Number 10f. Zip Code IISA Franklin Street 21740 202 E. Apt. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 14 Race - American Indian, Black, 12. Was Decedent Ever in U.S. "natural", or items ' White, etc. 1 Never Married 2 X Married Armed Forces? 2X No Yes White Widowed Divorced Give Yea Yes 2 X No specify. Specify. ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 honer of Health and Mental Hygiene. If item 27 is marked other than " ner tranmatic event, the Medical 21215-0036 Tavern Bartender n 12 18.Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Arthur Delmore Raines, Sr. Calledith Mae Reeder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD Judy Raines - sister 16951 Shadybrook Terr., Hagerstown, Md. 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 8-2-07 Hagerstown, Maryland tant: Hagerstown Crematory Donation 5 Other Specify: 22. Name and Address of Facility Minnich Funeral Home 21. Signatur — Funeral Service Licenses 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line Medical Death a Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last pue an/Medical UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death Physici Other (Specify, Yes 2 No 9 V Unknown Unknown the 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. é 1 Yes 2 No 3 Probably 4 V Unknown Chronic Alcoholism Completed Division of Vital Records, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 No 2 No 1 V Yes o the Hospital or Attending Physician: thin 24 hours after death. o the Funeral Director: After this certifi mpletely filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene Innatient 2 ER/Outpatient 3 ٩ 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural Yes 2 Pending 2 Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the ! one) 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifier 29b August 1, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner 31. Date filed (Month And Gen 3 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001 OCME 2006

**OCME** 

ORIGINAL

07-06018 Adriana A. Whalen

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|   |                | For State  |   | Cert                     | tificate of                      | Death                          |                 |              |                           | g. No.                |                         |  |
|---|----------------|--|---|--------------------------|----------------------------------|--------------------------------|-----------------|--------------|---------------------------|-----------------------|-------------------------|--|
| Physician/  | 1.             | gistrar<br>Decedent's Name (First, Midd                          |   |                          |                                  |                                |                 | l N          | Date of Death             | Day Y                 | 'ear                    | 3. Time of Death<br>0530 hrs           |
| Examiner  |                |  | a Alexi Wha                                 |                          |                                  | b. City, Town, o               | r Location of   |              | ugust 6, 2                |                       | ty of Death             |  |
|   | 4a             | Facility Name (if not institute St. Mary's Hospital              | on, give street and number                  | er)                      |                                  | Leonardto                      |                 | Dodu         |                           | St. Ma                |                         |  |
| Function  | 5              | Social Security Number   | 6. Sex 7. /                                 | Age (In yrs. la          | ist birthday)                    | If Under 1 Ye                  | ar If Under     | 24Hrs. 8.    | . Date of Birt            | h(MM/DD/YY            | YY) g. Bir              | thplace (State or                      |
| Funeral<br>Director   | 1              | 215–79–7851  | 1 M 2 XF                                    |                          | Yrs                              | Months Da                      | ys Hours        | Min.         | J111 v                    | 22,200                | Foreig                  | <sup>puntry)</sup> Marylan             |
|   |                | sual Residence of Decedent                                       | I IVI Z AI                                  |                          |                                  | 1 0 1 1                        |                 | 1            | July                      | 22,200                | <u> </u>                |  |
| any   | _              | Da. State 10b. County  |   | 10c. City,               | Town or Locat                    | ion                            |                 |              |                           |                       |                         | 10d. Inside City Limits                |
|   | - I N          | Maryland St.   | Mary's                                      |                          | Lexingt                          | on Park                        |                 |              |                           |                       |                         | 1 Yes 2 X N                            |
| aryland 8a-f show at once.  | 10             | De. Street and Number  |   |                          |                                  | 10f. Zip Code                  |                 |              | 11                        | g. Citizen of         | What Cou                | intry?                                 |
| the Maryland<br>a or 28a-f sh<br>tified at once   | 5/2            | 21625 Liberty  | Street. Apt                                 | . 1607                   |                                  | 2065                           |                 |              |                           |                       | JSA                     |  |
| with in 23; se not  | <u> </u>       | Marital Status   | 12. Was Decede                              | ent Ever in U.           | S. 13. Wa                        | s Decedent of F                | lispanic Orig   | in? (Specif  | fy Yes or No<br>an. etc.) | - 14. Ra<br>W         | ace - Ame<br>hite, etc. | rican Indian, Black,                   |
| or items 23. must be no   | 1 3            | X Never Married 2  | 1 Yes                                       | 2 X No                   |                                  |                                |                 |              |                           |                       | د. D1                   | cole                                   |
| ural", o  | 3 اح           |  | vorced If Yes, Give Year or Dates:          |                          |                                  | Yes 2 X N                      |                 | in a of work | , dono                    | 16b. Kind of          | fy: B1                  |  |
| hours<br>Dram   | 3              | 15. Decedent's Education (Sp                                     |   |                          | 16a. Deceder<br>during m         | nost of working li             | fe. DO NOT      | use retired  | ),                        | TOD. Tand of          | ,                       |  |
| 5-0036 ed within 72 ho tygiene. other than "na the Medical Ex   | i je           | Elementary/Secondary (0-12                                       | ) College (1-4                              | 01 5+)                   | N.                               | / A                            |                 |              |                           | N/A                   | A                       |  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica  | 티              | 7. Father's Name (First, Middl                                   | e. Last)                                    |                          | l                                |                                | 18.Mother       | s Name (Fi   | irst, Middle,             | Maiden Surna          | ame)                    |  |
| 71215-0036 Id be filed within 72 hou led be filed within 72 hou lental Hygiene. aarked other than "nat event, the Medical Exa   |                | Durell Antho   |   |                          |                                  |                                | T               | ameca        | Lasha                     | awn Bai               | rnes                    |  |
| D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. This market other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director   |                | ga. Informant's Name/Relation                                    |   |                          |                                  | g Address (Str                 |                 |              |                           |                       |                         |  |
| MD<br>nd 2 sho<br>lith and<br>m 27 is<br>aumati   |                | Durell Anthony W   | halen / Father                              |                          | 21625                            | Liberty S                      | Street,         |              |                           | exington              | Park.                   | Maryland 206<br>or Town, State         |
| Fe, I and I and Healt Healt I trans   |                | 0a. Method of Disposition  X Burial 2 Cremati                    | Pomovol from                                |                          | Place of Dispo<br>crematory or o | sition (Name of other place)   | cemetery,       | Augu         | oate<br>IST               |                       | •                       |  |
| ages<br>ent of<br>nt: Il  | Ш              | 4 Donation 5 Other   |   | Ch                       | arles Me                         | morial Gar                     | rdens           | 10,          | 2007                      | Leonar                | rdtown                  | , Maryland                             |
| Baltimore, MD 21 permit Pages I and 2 should Department of Health and Me Important: If item 27 is man injury or other traumatic ex  | 2              | 1. To lature of Funeral Service                                  |   | ()                       | 22.                              | Name and Addre                 | ess of Facility | att          | in ley-                   | aminer                | une:                    | ral Home, P.A                          |
| III TO PE OC  | 10             | Michael Kerry  | Hardine                                     | >                        |                                  | .O. Box 2                      |                 |              |                           |                       |                         | Approximate Interv                     |
| Physician   | 2              | 3a. Part I. Enter the dis ase, failure. List only one caus       | or mplications that cau<br>se on each line. | ed the drath             | n. Do not enter                  | the mode of dylr               | ng, such as c   | ardiac or re | espiratory ar             | est, shock, o         | ricait                  | Between Onset an<br>Death              |
| ledical<br>aminer   | 1              | mmediate Cause (Final disea                                      |   |                          |                                  | <u>n in infar</u>              | ncy             |              |                           |                       |                         | 5000                                   |
|   | (              | or condition resulting in death)                                 | Due to (or as a co                          | onsequence o             | of):                             |                                | -               |              |                           |                       |                         |  |
| 2   | ا ا            | Sequentially list conditions, fany, leading to immediate         | b<br>Due to (or as a c                      | onsequence o             | of):                             |                                |                 |              |                           |                       |                         |  |
|   | ١              | cause. Enter Underlying Caus<br>Disease or injury that initiated | e c.  |                          |                                  |                                |                 |              |                           |                       |                         |  |
| bs isi  |                | events resulting in death) Las                                   | t Due to (or as a c                         | onsequence o             | OT):                             |                                |                 |              |                           |                       |                         | Ì                                      |
| -   E E G   |                | X UNPENDED   | d   |                          |                                  |                                |                 |              |                           |                       |                         |  |
| 760, icate be exe   | Medical        | F FEMALE:  | 4450 127<br>#23a, 27                        |                          | anancv                           | 2,10/22/0                      |                 |              |                           | 23d. Da               | te of deliv             | ery                                    |
| 876<br>tificat<br>ng ph<br>as the   | <u>}</u>  2    | 3b. Was decedent pregnant in<br>past 12 months?                  | the 1 Live birt                             | th                       | 2 F                              | etal death                     | 3 Ectop         | ic pregnanc  | СУ                        | Mor                   | nth                     | Day Year                               |
| Box 687  The death certification is a set of the astending is the for use as the set of | /siclan/       |  | Internation                                 | nt at time of d          | eath 5                           | Other (Specify)                |                 |              |                           |                       |                         |  |
| he dez  | 2              | Part II. Other significant con                                   | 9 Olikilow                                  |                          | resulting in the                 | underlying caus                | se given in P   | art I.       | 23e. Did                  | tobacco use           | contribute              | to the cause of death?                 |
| ires that the de<br>signed by the<br>be detached f  | by .           | art II. Other Significant con                                    | ditions continuating to                     | Joan Dat Hot             |                                  |                                | Ū               |              | 1 🗌 Y                     | es 2 🗸 No             | 3 P                     | robably 4 Unknow                       |
| puires en sign  | ompleted by    |  |   |                          |                                  |                                |                 |              | 24a. Wa                   |                       | 24b. Were               | autopsy findings availal               |
| Soro<br>law red<br>has be   | 흺              |  |   | _                        |                                  |                                |                 |              | per                       | opsy<br>ormed?        | death                   |  |
| Rec<br>The licate licate lipage   | Š              |  |   |                          |                                  |                                | f D - e4h       | (Ob ant) an  | 1 Yes                     | 2 No                  | 1 🗸                     | Yes 2 No                               |
| tal Rec   | Be (           | 25. Was case referred to med<br>examiner?                        | Unanital                                    |                          | ER/Outpatie                      |                                | Other           |              | Home 5                    | Residence             | 6 🗸 01                  | ther: Scene                            |
| Physic<br>rr this   | <u>.</u> ol    | 1 Yes 2 No<br>27. Manner of Death                                | 28a. Date o                                 | patient 2                | 28b. Time o                      |                                | Injury at Wo    |              |                           | e how injury o        |                         |  |
| ding Pl   | ä              | A District   | (Month,                                     | Day,Year)                |                                  | 1                              | Yes 2X          |              | unk                       |                       |                         |  |
| SiO<br>Atten<br>deatl<br>ectors   | cati           | 2 Accident In  | vestigation 28e. Place                      | 6/2007<br>of Injury - At | Fnd 4:                           | oo am  <br>reet, factory, offi | ce building,    | etc. 2       | 28f. Location             | (Street and I         | Number or               | Rural Route Number, C<br>berty St. Apt |
| Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the fineral director, page 2 should be detached in the fineral director.  | Certification: | 11 d   | ould not be<br>etermined (Specify)          |                          | at home                          |                                |                 |              | or Town<br>1607 Le:       | State) ZIC<br>xington | Park.                   | perty St. Apt<br>MD                    |
| hou hou   |                | 29a. Certifier   | Physician: To the best                      | of my knowle             | edge death occ                   | curred at the time             | e, date and p   | lace, and o  | due to the ca             | use(s) and m          | anner as                | stated.                                |
| To the Ho<br>within 24<br>To the Fu<br>completely   | edical         | (Check only one) 2 Medical E                                     | xaminer: On the basis of<br>and manner sta  | f examination            | and/or investig                  | gation, in my opi              | nion, death o   | occurred at  | the time, da              | te and place,         | and due to              | o the cause(s)                         |
| £ .½ € .3   | ğ              | 29b. Signature and title of cer                                  | tifier                                      |                          |                                  | 29c. Lic                       | ense numbe      | er           |                           |                       |                         | (Month, Day, Year)<br>—                |
|   | 1              | Danna nu   | JINCENT, M.D                                | ),                       |                                  | 0                              | .C.M.E.         |              |                           | Augus                 | t 7, 200                | 7<br>                                  |
|   | +              | 30. Name and address of per                                      |   |                          | em 23a)                          |                                |                 |              | 2.04001                   |                       |                         |  |
|   |                | Donna M. Vincenti,   | MD Assistant M                              | ledical Exa              | aminer 1                         | 11 Penn Str                    | eet, Baltir     | nore, MI     | 21201                     |                       |                         |  |
|   |                | 31. Date filed (Month, Day, Ye                                   | 32. Re                                      | gistrar's Signa          | ature                            |                                |                 |              |                           |                       |                         |  |
| Registr   | rar            | AUG 0 9 2007   | A Company                                   | k d                      | 100                              |                                |                 |              |                           |                       |                         |  |
| HMH 17 Rev 1/20   | 001            |  | OCME  | 1                        | RIGIN                            | IAL                            |                 |              |                           |                       |                         |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Wright Edward John 24 2007 12:15 A July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 13118 Bedford Road, NE Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F 71 220-34-1751 Director Maryland 06/13/1936 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 1 No MD Allegany Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13118 Bedford Road, NE 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No 1959 — If Yes, Give Year or Dates: 1962 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Completed by Specify: 3 XWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Union 12 Pipefitter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Civic Wright Francis Agnes Charles Edward ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Pine View Drive, Ridgeley, WV Brent L. Biller / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Sunset Memorial Park 07/28/2007 Cumberland, MD 4 □ Donation 8 Other (Specify) 21. Signature of Funefal Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death rastric Carcinova Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 25 No 24a. Was an page 2 has autopsy performed? Yes 2/2/No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only only) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) ဥ 1 Tyes 20 No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Vatural 5 ☐ Pending investigation death. 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D46346 July 24, 2007 MI 10/1VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 625 Kent Avenue, Cumberland, Maryland 21502

Registrar DHMH 17 Rev 1/2001

State

Huma Shakil, M.D.,

JUL 2 5 2007

31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended item 1- State #10e & 19b, per f.home, with et certificate of Death 8/6/2007, 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day D Year **Physician** 2007 14:08 PM Patsy Elaine Whitlock /Medical 4b. City, Town, or Location of Death Facility Name (If not imptitution, give street and number) 4c. County of Death Examiner EGIONAL MEDICAL DALISBURY Wicomas LENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 10/30/1956 6. Sex Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 XF 50 MD 218-38-2212 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f sl idical Examiner must be notified Director 1 ☐ Yes 2 TNo MD Worcester Berlin 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 8720 Evans Rd. 20 Evans Rd. 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. oe filed within 72 hours after al Hygiene. I other than "natural", or ite 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: ģ Specify: White 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Restaurant Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If item 27 Is marked of any injury or other traumatic ever George Edward Riley, Sr. Winifred J. Larsen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8720 Evans Rd., Berlin, Md. 21811
20 Evans Rd., Berlin, MD. 21811 19a. Informant's Name/Relationship (Type. Print) John Wesley Whitlock, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/3/2007 4 ☐ Donation 5 ☐ Other (Specify) Bowen Cemetery Newark, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 Par. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** ALUTE MYUCARDAL INFANCTI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of). If any, leading to immedic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-tran Due to (or as a consequence of): 68760, attending physician for use as the burial requires that the death certificate be Physician/Medical Box IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) signed by the a d be detached f Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division ór Vital Records, þ 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No performed' To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Man of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 29a. Certifier 1 vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D38353 07-30-2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lisbury, md Jisoi. Dr. Desmarais BA8 100 a

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 1

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| iges 1 and 2 should be lited within 72 hours after death with the maryland  The flash than Abental Hygiens in the Maryland in the marked other than 1 flash 27 is marked other than 1 matural, or item 27 is marked other than 1 marked other than 2 as or 28a-1 show and 1 in a Maryland in a flash 2 as or 28a-1 show and 1 in a Maryland in a flash 2 as or 28a-1 show and 1 in a Maryland in a flash 2 as or 28a-1 show and 2 as or 28a-1 show a | by Funeral Director | 217-36-0401  Usual Residence of Decedent  10a. State 10b. County  MD Wicomi  10e. Street and Number  31546 Dagsboro  11. Marital Status  1 □ Never Married 2 Married  | re street and num o Road Sex 12M 2DF   | 7. Age (In yrs.<br>86            | last birthday) Yrs. ity, Town or Lo | De.  | wn, or Location of De<br>1mar<br>(ear   If Under 24 H<br>lays Hours Mi | s. 8. Date of Birt                        | 9, 2007<br>4c. County of Wi        | comi         | 3. Time of Death 6:47 p                            |
|--|---------------------|---|--|----------------------------------|-------------------------------------|--|--|---|------------------------------------|--------------|--|
| /Medic<br>Examin<br>Funeral<br>Director  | by Funeral Director | 4a. Facility Name (If not institution, given 31546 Dagsbord 5. Social Security Number 217-36-0401  Usual Residence of Decedent  10a. State 10b. County  MD Wicomi  10e. Street and Number 31546 Dagsboro  11. Marital Status  1 Never Married 2 Married | e street and number of Road  Road  Sex IMM 2 F   | 7. Age (In yrs.<br>86            | 5 Yrs.                              | De.  | 1mar<br>rear If Under 24 H   | July 2 ath  S. 8. Date of Birt (Month, Da | 4c. County of Wi                   | of Death     |  |
| Examir<br>Funeral<br>Director  | by Funeral Director | 31546 Dagsbord  5. Social Security Number 217-36-0401  Usual Residence of Decedent  10a. State 10b. County MD Wicomi  10e. Street and Number 31546 Dagsboro  11. Marital Status 1 □ Never Married 2 Married   | Road  Sex  IMM 2 F   | 7. Age (In yrs.<br>86            | 5 Yrs.                              | De.  | 1mar<br>rear If Under 24 H   | s. 8. Date of Birt<br>(Month, Da          | Wi                                 | comi         | co   |
| Director   | by Funeral          | 5. Social Security Number 217-36-0401  Usual Residence of Decedent  10a. State 10b. County  MD Wicomi  10e. Street and Number  31546 Dagsboro  11. Marital Status  1 □ Never Married 2 ☑ Marned   | Sex<br>I⊠M 2□F<br>CO<br>Road   | 86                               | 5 Yrs.                              | If Under 1 Y<br>Months D                         | fear If Under 24 H   | n. (Month, Da                             | h                                  |              | co   |
| Director   | by Funeral          | 217-36-0401  Usual Residence of Decedent  10a. State 10b. County  MD Wicomi  10e. Street and Number  31546 Dagsboro  11. Marital Status  1 □ Never Married 2 ☑ Married  | DEM 2□F  | 86                               | 5 Yrs.                              | Months D   |  | n. (Month, Da                             | h<br>v. Year)                      | o District   |  |
| 0  | by Funeral          | Usual Residence of Decedent  10a. State 10b. County  MD Wicomi  10e. Street and Number  31546 Dagsboro  11. Marital Status  1 \( \text{Never Married} \) 2 \( \text{Marned} \) Marned   | Road   |                                  |                                     | ocation  |  |   | 1020                               | Goun<br>Mary | lace (State or Foreign<br>try)<br>Land             |
| or within 1.4 hours arter obeath with the maryland<br>gigne.<br>et then "natural", or itame 23a or 28a-f show<br>the Medical Exactinar must be notified at   | by Funeral          | MD Wicomi  10e. Street and Number  31546 Dagsboro  11. Marital Status  1 □ Never Married 2 ☒ Marned   | Road   | 10c. Ci                          | ty, Town or Lo                      | ocation  |  | 10/0//                                    | 1920                               | mary         | 20114  |
| o which to nows and observation the Mary<br>erthan "naturat", or itame 23a or 28a-1 sh<br>. Ita Medical Exacilinar maniba notilified   | by Funeral          | 10e. Street and Number 31546 Dagsboro 11. Marital Status 1 □ Never Married 2 🖾 Married  | Road   |                                  |                                     |  |  |   |                                    | 11           | Od. Inside City Limit                              |
| or within 7 c froms after death with the<br>grighes.<br>et then "natural", or frame 23e or 28e<br>the Medical Exatural must be noti  | by Funeral          | 31546 Dagsboro  11. Marital Status  1 Never Married 2 Married   |  |                                  |                                     |  | Delmar   |   |                                    |              | 1 ☐ Yes 2 ☒ N                                      |
| ou within 12 hours aller death will<br>gjene.<br>ethen "natural", or flame 23a. o<br>the Medical Exacilina Enable.   | by Funeral          | 11. Marital Status<br>1 ☐ Never Married 2 🔀 Married   |  |                                  |                                     | 10f. Zip Co                                      | ode  |   | 10g. Citizen of W                  | hat Coun     | try?   |
| or within / £ nours after deal<br>giene.<br>er than "natural", or fame 2<br>er the Medical Exa. in er mi   | by                  | 1 ☐ Never Married 2 🖾 Married   | I  |                                  |                                     | 2  | 21875  |   | USA                                | A            |  |
| ou within it a hours after<br>giene.<br>er then "netural", or itt  | by                  |   | 12. Was Dece   | dent Ever in U                   | J.S. 13.                            | Was Decedent                                     | t of Hispanic Origin?<br>Cuban, Mexican, Pu                            | (Specify Yes or No<br>erto Rican, etc.)   | 14. Race<br>Black                  | - Americ     | an Indian,<br>etc.                                 |
| su within 72 hours<br>giene.<br>er than "natural",<br>the Medical Exe.   |                     |   | 1 ☐ Yes<br>If Yes, Give  | 2 <b>]</b> [] No                 |                                     | 1 ☐ Yes 2 🔀                                      |  |   | Specify:                           | wh           | nite   |
| ou within 72 r<br>giene.<br>er than "natu<br>. It e Medica   |                     | 3 Widowed 4 Divorced  | Year or Da   | tes:                             |                                     |  |  |   | 40th Mind of Dec                   |              |  |
| giene.<br>er than  | Completed           | 15. Decedent's E<br>(Specify only highest gr  |  |                                  | (Give                               | dent's Usual O<br>kind of work a<br>DO NOT use n | tone during most of w  | rorking                                   | 16b. Kind of Bu                    | sinessym     | lustry   |
| 0 0  | E D                 | Elementary/Secondary (0-12)   | College (1-  | 4or 5+)                          | ,,,,,,                              | Farme  |  |   | Pou!                               | trv          |  |
| <u> </u>   |                     | 17. Father's Name (First, Middle, Las.  | ·)   |                                  | 1                                   |  |  | ame (First, Middle,                       |                                    |              |  |
| o be<br>ked o<br>c eve   | o Be                | John Bennett Yo   | _  |                                  |                                     |  | Lena   | Huffman                                   |                                    |              |  |
| Shour<br>nark<br>mark  | T <sub>o</sub>      | 19a. Informant's Name/Relationship  |  |                                  | 19b. Mailir                         | ng Address (S                                    | treet and Number or  |   | er, City or Town, S                | State, Zip   | Code)  |
| ith ar<br>27 is<br>r trau  |                     | Edith Longacre  | Yoder (w   | ife)                             | 3154                                | 46 Dags  | boro Road  | Delm                                      | ar, MD                             | 2187         | <b>'</b> 5   |
| Department of Health a Important: If Item 27 is any injury or other training.  |                     | 20a. Method of Disposition  |  | 20b. I                           | Place of Dispo                      | osition (Name of                                 | of<br>r place)   | Date                                      | 20c. Location - 0                  | City or To   | wn, State  |
| ent o<br>ry or   |                     | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Speci   |  | Sa Sa                            | lisbury<br>nnonit                   | V  | !.   | . 3, 2007                                 | Delmar.                            | Mar          | vland  |
| orta<br>inju   | 1                   | 21. Signature of Funeral Service Lice   | nsee   | 110                              | 22                                  | 2. Name and A                                    | Address of Facility  |   |                                    |              |  |
| Depa<br>Impo<br>any ir   |                     | Ja- Chile   | 1  |                                  | 1.3                                 | 3 F Cr   | neral Hom<br>ove St.   | Delmar.                                   | DE 1994                            | 0            |  |
| hysician<br>/Medical<br>xaminer  |                     | 23a. Part1. Enter the disease, or construct, or hear failure. List only immediate Cause (Final disease or condition resulting in death)   | a  | ictasta<br>or as a consec        | itic 1                              | Proste.  | TP, Ime  | 01-                                       |                                    |              | Approximate<br>Interval Between<br>Onset and Death |
| - St   | Examiner            | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | b. Due to (c   | or as a consec                   | quence of):                         |  |  | ION APPROVED BY                           | TUS                                |              |  |
| cermicate be executed ding physicien and use as the burial-transit   | dical Exar          | that initiated events<br>resulting in death) Last   | Due to (d  | or as a consec                   | quence of):                         |  | Œ U  | ION APPROVED BY                           | ,                                  |              |  |
| ed by the attending pl<br>detached for use as t  | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  |  | nth 2 ☐ Feta<br>ant at time of c | al death 3                          | □Ectopic pregr<br>□ Other (special               | nancy  |   | 23d. Date<br>Mor                   | of delive    | ery<br>Day Year                                    |
| sign<br>d be   | þ                   | Part II. Other significant conditions  Subclural No   | contributing to de   | ath but not res                  | sulting in the u                    | inderlying caus                                  | se given in Part I.  |   |                                    |              | ne cause of death?                                 |
| ate has b<br>page 2 s  | Completed           |   |  |                                  |                                     |  |  | 24a. Was<br>autor<br>perfo<br>1 Yes       | osy p                              |              | psy findings availa<br>mpletion of cause<br>2 No   |
| is certificate<br>director, pag  | Be                  | 25. Was case referred to medical examiner?  | Hospital   |                                  |                                     |  | Other  | eath (Check only o                        |                                    |              | -  |
| S 00   | 2                   | 1 XYes ZW NO  | The state of the s |                                  | ER/Outpatier                        |  |  | Home 5 Resident                           | dence 6 Other                      |              | r)   |
| After  | Certification:      | 27. Manuar of Death 1 ☐ Pending   | 1.10   | f Injury<br>7, Day Year)         | 28b. Time of                        |  | Injury at Work? 1 ☐ Yes 24☐ No   | Zou. Describe                             |                                    |              | 11   |
| death<br>ctor: /<br>the f  | cat                 | 2 Accident investigate 3 Suicide 6 Could not  | 00 Place   |                                  | Unknow<br>nome, farm, str           |  |  | 28f. Location (                           | Subject Street and Number          | er or Rura   | A Route Number.                                    |
| 9 = -  | rtif                | 4 Homicide determined   | buildin  | g, etc. (Speci                   | ify)                                | reet, ractory, o                                 | 11100  | City or To                                | wn, State) <b>315</b> 4            | 46 Da        | agsboro  |
| within 24 hours after deatl<br>To the Funeral Director:<br>completely filled in by the   |                     | 29a. Certifier 1 Certifying P   | Home   | best of my kni                   | owledge, deat                       | h occurred at t                                  | the time, date and pla   |   | <b>Lelmar</b> , locause(s) and man |              |  |
| 24 hr<br>Fun<br>etely  | dical               | (Check only 2 Medical Exa   | miner: On the ba   | sis of examina                   | ation and/or in                     | vestigation, in                                  | my opinion, death oc   | curred at the time,                       | date and place, a                  | and due to   | the cause(s)                                       |
| within 24 hours at<br>To the Funeral D<br>completely filled in   | Me                  | 29b. Signature and title of centrier  |  |                                  |                                     | 29c. L   | icense number  |   | 29d. Date signed                   | (Month,      | Day, Year)   |
| · <b>s ⊢</b> ű   |                     | <b>)</b> ()   | M  | $\sim$                           |                                     | 1  | 054127   |   | 77/                                | ZE /5        | 7  |
| Im   |                     | 30. Name and address of person who  | completed cause  | of death (Ite                    | m 23a) (Type,                       | Print)   | Luce   | mo i                                      | 7.1804                             | -,0          |  |
| Sta  | ate                 | 31. Date filed (Month, Day, Year)   | 32 P   | distrar's Sign                   | - 10                                |  |  |   |                                    |              |  |

# Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

|  |                  | Please  |  |                   | ck Indelible Ink  |   |                                      | _                            | ole.                  |  |
|--|------------------|---|--|-------------------|---|---|--------------------------------------|------------------------------|-----------------------|--|
|  |                  | For   | State of Ma  | aryland /         | Department of H   |   | Mental Hyg                           | giene                        |                       |  |
|  |                  | 1 - State<br>Registrar  |  |                   | Certificate of  | Death                                   |                                      | Reg. No.                     |                       | 23257  |
| Physicia   | an               | Decedent's Name (First, Middle, La  | ist)   | - 1               |   |   | Date of Dea     Month                | ath<br>Day                   | Year                  | 3. Time of Death                             |
| /Medic   |                  | Edward  | 1 100  | 21_               |   |   | 08                                   | 07 20                        | 07                    | 2142 1                                       |
| Examin   | er               | 4a. Facility Name (If not institution, gi   | 7 /  | 100               | 4b. City, Town, o   | or Location of Deat                     | h                                    | 4c. County of                |                       | 1 0 0  |
|  |                  | 5. Social Security Number 6.  | Sex 7. Ag  | e (In yrs. last i | birthday) If Under 1 Year                                   | 5 DUYU                                  | 8. Date of Birt                      | WIC                          |                       | ace (State or Foreign                        |
| Funeral<br>Director  |                  |   | 1 <del>∏</del> M 2□F   | 78                | Yrs. Months Days  | Hours Min.                              | Nov 4,                               | /, Year)                     | Coun                  | sylvania                                     |
|  |                  | Usual Residence of Decedent   |  | 70_               |   |   | NOV 4,                               | 1920 ]                       | emi                   | sylvania                                     |
| rylan<br>how   | _                | 10a. State 10b. County  |  | 10c. City, To     | own or Location   |   |                                      |                              | 11                    | Od. Inside City Limits                       |
| e Ma<br>8a-f s<br>ptified  | Director         | MD Wicomio  | 0  | D                 | elmar   |   |                                      |                              |                       | 1 □Yes 2 No                                  |
| vith the   |                  | 10e. Street and Number  |  |                   | 10f. Zip Code   |   |                                      | 10g. Citizen of W            | hat Coun              | try?   |
| s 23a  | eral             | 9326 Colonial Mi  |  |                   | 10 10 - 0 - 1 - 1 (1  | 21875                                   |                                      | USA                          |                       | - 1  |
| ter de<br>Item   | Funeral          | <ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>                          | 12. Was Decedent<br>Armed Forces?  |                   | 13. Was Decedent of H<br>If Yes, specity Cub                | an, Mexican, Puer                       | pecify Yes or No-<br>to Rican, etc.) | Black                        | - America<br>, White, |  |
| ırs af<br>II", or<br>Xaml  | by F             | 3 ☑ Widowed 4 ☐ Divorced  | 1 Yes 2 □ I<br>If Yes, Give<br>Year or Dates:  | *52 <b>-</b> 54   | 1 ☐ Yes 2 🔀 No  | Specify:                                |                                      | Specify:                     | whi                   | te   |
| filed within 72 hours after death with the Maryland<br>Hygiene.<br>uther than "natural", or Items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at | Completed        | 15. Decedent's E  | ducation   |                   | Sa. Decedent's Usual Occur                                  | pation                                  | <i>L</i> :                           | 16b. Kind of Bus             | siness/Inc            | lustry                                       |
| thin 7<br>e.<br>an "r<br>Med   | adr.             | (Specify only highest gi<br>Elementary/Secondary (0-12)   | College (1-4or 5   | i+)               | (Give kind of work done<br>life. DO NOT use retire          | ed)                                     | rking                                |                              |                       |  |
| ed wil   | 5                | 12  | Ò  |                   | plumber   | Т                                       |                                      | commerc                      |                       |  |
| be fill<br>tal H<br>d oth<br>even  | Be               | 17. Father's Name (First, Middle, Las   |  |                   |   |   | me (First, Middle,                   |                              | ,                     |  |
| 2 should be<br>and Mental<br>Is marked can<br>aumatic ev   | 2                | Charles Frank Abe   |  | 1.                |   |   | Florence                             |                              |                       |  |
| 12 st<br>h and<br>7 Is n<br>traun  |                  | 19a. Informant's Name/Relationship  |  |                   | 9b. Mailing Address (Street                                 |   |                                      |                              |                       | Code)  |
| 1 and<br>Health<br>em 27<br>other tr   | -                | Alice Price/exec  | utor   | 20b. Place        | 36590 Old Sta   | T T                                     | Delmar,                              | DE 1994<br>20c. Location - ( |                       | wn. State                                    |
| Pages<br>nent of<br>int: If its<br>iry or o  |                  | 1 ☐ Burial 2 ☐ Cremation 3 [  |  | ceme              | tery, crematory or other pla                                | ice)                                    |                                      |                              | ,                     | ,  |
|  |                  | 4 ☑ Donation 5 ☐ Other (Special Service Lice Ronal d S  | P:   | 1.                | 22. Name and Addre  | ess of Facility                         | 1 (55 37                             | D 1.1                        |                       |  |
| permit. Departimonts any Inji  |                  | Ronald S.   | Wade, Dir  | ector             | Baltimore.  |   |                                      | Baltimo                      | re S                  | treet  |
|  |                  | 23a. Part Enter the disease, or cor<br>shock or heart failure. List only                                    | plications that caused   | the death. D      |   |   |                                      | rest,                        |                       | Approximate<br>Interval Between              |
| Physician  |                  | Immediate Cause (Final disease or condition   | Men  | betati            | luna  | Cosi                                    | cer                                  |                              |                       | Onset and Death                              |
| /Medical   |                  | resulting in death)   | Due to (or as  | a consequenc      | ee of):   | ceji                                    | 40                                   |                              |                       |  |
| Examiner   |                  | Sequentially list conditions  | b  |                   |   |   |                                      |                              |                       |  |
| gi gg  | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as  | a consequenc      | ee of):   |   |                                      |                              |                       |  |
| oe executed<br>cian and<br>ourial-transit  | хаш              | that initiated events resulting in death) Last  | c  | a consequenc      | e of):  |   |                                      |                              |                       |  |
| be egician<br>buria  | - 1              |   | 3 .  |                   |   |   |                                      |                              |                       |  |
| rtificate by<br>g physici<br>as the bu   | Physician/Medica |   | d  |                   |   |   |                                      |                              |                       |  |
| eath certi<br>attending<br>for use a   | Ž.               | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome   |                   |   |   |                                      | 23d. Date                    | of delive             | ry   |
| death<br>e atte  | icia             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 1□Live birth<br>4□Pregnant at  |                   |   | :y<br>                                  |                                      | Mon                          | ith                   | Day Year                                     |
| by the a   | hys              | 9 Unknown   | 9□ Unknown   |                   |   |   |                                      |                              |                       |  |
| The law requires that the death certificate be<br>ate has been signed by the attending physicial<br>bage 2 should be detached for use as the bur                     | by P             | Part il. Other significant conditions   | contributing to death b  | ut not resulting  | in the underlying cause giv                                 | ven in Part I.                          | 23e. Did to                          |                              |                       | e cause of death?                            |
| requir   | ted              |   |  | <del></del>       |   |   | X                                    | es 2 No                      | 3 Prob                | ably 4 □Unknown                              |
| law I  | Completed        |   |  |                   |   |   | 24a. Was autop                       | sy p                         | ere autor             | osy findings available inpletion of cause of |
|  | Co               |   |  |                   |   |   | perfo                                |                              | eath?<br>□Yes         | 2 No   |
| sician: The law<br>certificate has t<br>rector, page 2 s   | Be               | 25. Was case referred to medical examiner?  | Hospital.  |                   | Outpatient 3 DOA Oth  | oer:                                    | ath (Check only o                    |                              |                       |  |
| this aldi  | 2                | 1 ☐ Yes No 27, Manger of Death  | 28a. Date of Inju  |                   | Sulpatient S DOA  | 4 LI Nursing F                          | lome 5 Resid                         | ence 6 Othe                  |                       | ")   |
| ding F<br>th.<br>: After<br>funera   | tion             | Natural 5 Pending investigation   | (Month, Da)  |                   | Injury Wor  | rk?<br>]Yes 2∐No                        | 200. 2000/120 11                     | ow injury occurre            |                       |  |
| al or Attendii<br>s after death.<br>Il Director: A<br>id in by the fu  | ifica            | 3 Suicide 6 Could not be determined   | 28e. Place of inju   | ury - At home,    | farm, street, factory, office                               | *************************************** | 28f. Location (S                     | treet and Numbe              | r or Rura             | Route Number,                                |
| s afte   | Certification:   | 4Hornicide  | building, et   | с. (Бреспу)       |   |   | City or Tow                          | n, State)                    |                       |  |
| losph<br>hour<br>uner  |                  | 29a. Certifier Certifying P   | hysician: To the best  | of my knowled     | ge, death occurred at the ti<br>and/or investigation, in my | ime, date and place                     | e, and due to the                    | cause(s) and mar             | nner as st            | ated.  |
| To the Hospital of within 24 hours af To the Funeral D completely filled in  | Medical          | one)  29b. Signature and title of certifier   | and manner sta   | ated.             | 29c. Licens   |   | Т                                    |                              |                       |  |
| 5 × × 5  |                  | 29D. Signature and title of certifier   |  |                   |   |   |                                      | 29d. Date signed             | > _/                  | Day, rear                                    |
|  |                  | 30. Name and address of person who  | completed cause of   | eath (Italy 22)   | (Type, Print)<br>Hospire                                    | 1161                                    | 10                                   | 0-8                          |                       |  |
|  |                  | De la 1 Count   | MA Cause of a  | setal             | Hospin  | Po Box                                  | 1733                                 | Salish                       | M                     | 2/802  |
| Sta  | te               | 31. Date filed (Month, Day, Year)   | 139  | ar's Signature    | 7,541.00  | 7 7 1                                   |                                      |                              | )/                    |  |
| Registr  | ar               | AUG 1 6   | 2007   | w &               | Grante)   |   |                                      |                              |                       |  |
| MH 17 Pay 1/20   |                  |   | and the same of th |                   | 0 1   |   |                                      |                              |                       |  |

|                                |   | •                   | For<br>State<br>Registrar   | State of Maryla   |                                      | artment of He<br>tificate of D   |   | Reg  | 6 U / I  | 26266  |
|--------------------------------|---|---------------------|---|---|--------------------------------------|--|---|--|--|--|
|                                | Physici   |                     | 1. Decedent's Name (First, Middle, Last) Arlo   | D.  | Ande                                 | erson  |   | 2. Date of Death<br>Month<br>August        | Day<br>11,2007   | 3. Time of Death 0136 M                            |
|                                | /Medic<br>Examin  |                     | 4a. Facility Name (If not institution, give st  | Hospital  |                                      |  | shington  |  | 4c. County of Death Prince G   |  |
|                                | Funeral<br>Director   |                     | 5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | M 2□F 7. Age (In yi   | s. last birthday)<br>Yrs.            |  | If Under 24 Hrs.<br>Hours Min.                    | 8. Date of Birth (Month, Day, You Aug. 26, | ear) Cour  | place (State or Foreign<br>ntry)<br>LNOIS          |
|                                | the Maryland<br>28a-f show  | ector               | Usual Residence of Decedent  10a. State  10b. County  Maryland Prince Ge  10e. Street and Number  |   | City, Town or Lo                     | cation<br>cokeek   |   | 10g  | . Citizen of What Cour   | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No ntry?       |
| 36                             | be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or items 23e or 28a-f show event, the Midfral Exciptor must be notified at | by Funeral Director | 1300 Laurel Drive   | 2. Was Decedent Ever in<br>Armed Forces?<br>1 XYes 2 □ No 1<br>If Yes, Give<br>Year or Dates: 1 | 943-                                 | 20607<br>Was Decedent of Hisp<br>If Yes, specify Cuban,                            | panic Origin? (Spe<br>Mexican, Puerto<br>Specify: | scify Yes or No-<br>Rican, etc.)           | U.S.A  14. Race - Americ Black, White, Specify: White                                  | can Indian,<br>etc.                                |
| 21215-00                       | i within 72 hour<br>liene.<br>r than *natural<br>the Modical Ex   | Completed t         | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   | ation   | 16a. Dece<br>(Give<br>life.          | dent's Usual Occupati<br>kind of work done du<br>DO NOT use retired)<br>thematicia | ring most of worki                                | ng   | b. Kind of Business/In   |  |
| land 2                         | 12 should be filed within 'n and Mental Hygiene. 7 is marked other than 'r raumetic event, the Med  | To Be C             | 17. Father's Name (First, Middle, Last) Alfred Anders   | son   |                                      |  | A1ma  | West                                       |  |  |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumetic en 2000.                                   |                     | 19a. Informant's Name/Relationship (Type Betty E. Anderson 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rev. 4 □ Donation 5 □ Other (Specify)  | (Wife)  | 130                                  | O Laurel Dosition (Name of matory or other place)                                  | rive Acc  | okeek, Ma                                  | City or Town, State, Zif<br>aryland 200<br>C. Location - City or To<br>linton, Ma      | 607<br>own, State<br>ryland                        |
| Baltir                         | permit. P<br>Departme<br>Importan<br>eny injur  |                     | 21. Signature of Funeral Service Vicense  | M00257  | 6                                    |  | <sub>of Facility</sub> Le<br>exandria             | e Funera<br>Ferry R                        |  | n, MD 20735  |
|                                | Physician<br>/Medical<br>Examiner   | iner                | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | ue to (or as a orns   | than sequence on:                    | ter the mode of dying,   | such as cardiac c                                 | or respiratory arrest                      |  | Approximate<br>Interval Between<br>Onset and Death |
| 68760,                         | death certificate be executed<br>e attending physician and<br>of for use as the burial-transit  | Aedical Examin      | that initiated events cresulting in death) Last   | Due to (or as a cons  | sequence of):                        |  |   |  |  |  |
| .O. Box                        | that the death certifice<br>led by the attending ph<br>detached for use as t  | Physician/Me        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \triangle | 3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown             | etal death 3                         | □Ectopic pregnancy □ Other (specify)   |   |  | 23d. Date of deliv<br>Month  | Day Year   |
| ords, P.                       | w requires that the<br>been signed by th<br>should be detache   | by                  | Part II. Other significant conditions con   | tributing to death but not  | resulting in the u                   | inderlying cause giver   | n in Part I.                                      |  |  | the cause of death?  bably 4                       |
| al Rec                         | The law<br>ate has b<br>page 2 s  | Completed           | FJALIOSI /LOFIL   | Coope   | 10 V43                               | ali b  | 26 Place of Death                                 | autopsy<br>performe                        | prior to co<br>death?<br>☐MNo 1 ☐ Yes  | ompletion of cause of                              |
| Division of Vital Records,     | ing Phys<br><br>After this i<br>tuneral dii   | atlon; To Be        | 25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Matural 5 Pending 2 Accident investigation   | ospital: 1  Inpatient 2<br>28a. Date of Injury<br>(Month, Day Year                              | 28b. Time (Injury                    | of 28c, Injury a   | 4 ☐ Nursing Ho                                    |  | ce 6 □Other (Speci   | ( <b>fy</b> )                                      |
| Divis                          | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune  | Certification;      | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of Injury - A<br>building, etc. (Sp.   | ecify)                               |  |   | City or Town,                              |  |  |
|                                | To the Hospital<br>within 24 hours of<br>To the Funeral I<br>completely filled  | Medical             | 29a. Certifier (Check only one)  2 Medical Exeminates  29b. Signature and title of certifier  | er: On the best of my<br>ner: On the basis of exam<br>and manner stated.                        | knowledge, dea<br>nination and/or ii | th occurred at the time<br>evestigation, in my opi                                 | nion, death occur                                 | red at the time, dat                       | e and place, and due to be and place, and due to be and place.  d. Date signed (Month) | to the cause(s)                                    |
| ş                              | 5 × F × S   |                     | A Tri   | Do y mpleted cause of death (   | Item 23a) (Type                      | 200  | 609r  | 14 0                                       | 08/14/3  | 2007   |
|                                | SI  | ate                 | 30. Name add address of person who co   | 4 7801<br>32. Registrar's Si  | Old<br>gnature                       | Brown  | th Chu  | e #202                                     | Clinio   | n LUD.<br>2073                                     |
|                                | Regist  |                     | 100 11 200  | LAUNT 1 6 2   | 2007                                 | e de   | A 34  |  |  |  |

|  | -                 | For<br>State<br>Registrar  | State of Marylar   |                                     | artment of I                                    |  |                                       | giene                          | 07                             | 201   | 25                   |
|--|-------------------|--|--|-------------------------------------|---|--|---------------------------------------|--------------------------------|--------------------------------|---|----------------------|
| [  |                   | Decedent's Name (First, Middle, Last)  |  |                                     |   |  | 2. Date of Dea                        | ith                            |                                | 3. Time of [  | Death                |
| Physicia   |                   | Shirley W.   | Bowen  |                                     |   |  | August                                | 12 2                           | Year<br>2007                   | 5:50  | РМ                   |
| /Medic<br>Examin   | , it              | 4a. Facility Name (If not institution, give s  |  |                                     | 4b. City, Town, o                               | or Location of Deat                      |                                       | 4c. County                     |                                | 0.00  |                      |
| LXAIIIII   | 51                | 36 Brookfield Road   |  |                                     | Pa:   | sadena                                   |                                       | Anne                           | Arur                           | nde]  |                      |
| Funeral  |                   | 5. Social Security Number 6. Sex   | 7. Age (In yrs   | last birthday)                      | If Under 1 Year                                 | If Under 24 Hrs.                         | 8. Date of Birth                      |                                | 9. Birthp                      | lace (State or  | r Foreign            |
| Director   |                   | 219-12-9038 1□ Usual Residence of Decedent   | M 2♥ F   | 84 Yrs.                             | Months Days                                     | Hours Min.                               | Feb. 08                               | 1923                           | Cour                           | MD_   |                      |
| ylanc<br>Iow   |                   | 10a. State 10b. County   | 10c. C   | ty, Town or Lo                      | ocation   |  |                                       |                                | 1                              | 0d. Inside City   | •                    |
| Mar<br>Fied  | ģ                 | Maryland Anne Aru  | ndel   | Pasa                                | ıdena   |  |                                       |                                |                                | 1 ☐ Yes   | 2 No                 |
| h the  | ire               | 10e. Street and Number   |  |                                     | 10f. Zip Code                                   |  |                                       | 10g. Citizen of \              | What Cour                      | ntry?   | -                    |
| h wit<br>23a c   | Funeral Director  | 36 Brookfield Roa  | d  |                                     | 21  | 122                                      |                                       | USA                            |                                |   |                      |
| deat<br>ms (   | ner               |  | Was Decedent Ever in U<br>Armed Forces?  | J.S. 13.                            | Was Decedent of I                               |  | pecify Yes or No-                     | 14. Rac                        | e - Americ                     |   |                      |
| 6 after or ite   | 교                 | 1 ☐ Never Married 2 ☐ Married  | 1 X Yes 2 No<br>If Yes, Give   |                                     | 1 ☐ Yes 2 🖾 No                                  |  | to ricali, etc.)                      |                                | k, White,                      |   |                      |
| OO3  | ρ                 | 3 Widowed 4 □ Divorced   | Year or Dates:   |                                     | 10163 212110                                    | оресну.                                  |                                       | Specify                        | / whi                          | te  |                      |
| 5-0<br>5-0<br>72 hv  | etec              | 15. Decedent's Educ<br>(Specify only highest grade   |  | i (Give                             | dent's Usual Occup                              | during most of wo                        | rking ı                               | 16b. Kind of B                 | usiness/Ind                    | dustry  |                      |
| 21215-0036  d within 72 hours after death with the Maryland rigiene. er than "natural", or items 23a or 28a-f show it, the Medical Examiner must be notified at  | Completed         | Elementary/Secondary (0-12)  | College (1-4or 5+)   | life.                               | DO NOT use retire                               | ,  |                                       | _                              |                                | -   |                      |
| d 21<br>filed w<br>Hygie<br>other ti   | 8                 | 12 17. Father's Name ( <i>First, Middle, Last</i> )  |  |                                     | Sal   |  | me (First, Middle,                    |                                | <u>Retai</u>                   |   |                      |
| and<br>be fintal Fed out   | Be                |  | C  | Conn                                | faa+  | _  |                                       | waiden guman                   | •                              |   |                      |
| aryla<br>should I<br>and Men<br>s marked<br>umatic   | ှင                | Harrison  19a. Informant's Name/Relationship (Typ.   | C C  |                                     | ofoot<br>ng Address (Street                     |  | Myrtle                                | r City or Town                 |                                | ndler   |                      |
| Maryland nd 2 should be file tith and Mental Hy 27 is marked oth   |                   | Darrell M Bowen  | son  | 1                                   | Carroll   |  |                                       |                                | State, Zip                     | Codey   |                      |
| re, N<br>1 and<br>Health<br>tem 27<br>other tr   | -                 | 20a. Method of Disposition   | 20b.   |                                     | osition (Name of<br>matory or other pla         |  | Date                                  | 20c. Location -                | City or To                     | wn, State   |                      |
| Pages nent of I  |                   | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)  |  |                                     | ge Cemerpia<br>dge Cemet                        |  | 6/2007                                | Howard                         | d Co                           | Maryl   | and                  |
| 프 교환원들 [   |                   | 21. Signature of Fune - Service Licens   |  |                                     | 2. Name and Addre                               |  | tallings                              |                                | -                              |   | una                  |
| Depa Impo  |                   | Man 2 St   | , ,  |                                     | 3111 Mou  | 31                                       | ad Pasade                             | na.MD 2                        | 1122°                          | e P.A.  |                      |
| Physician ate be executed  Examiner  itysician and the burial-transit  | Examiner          | 23a. Parth Enter the disease, or complete shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consect to for | quence of):  Lee Q  quence of):  Au | iterio S  | ilenofiz                                 |                                       |                                | 7                              | Approximate Interval Betwo  | veen                 |
| I Records, P.O. Box 687666, The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit          | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□Yes 2,KNo 9□Unknown   | Sc. If yes, outcome pf pregr<br>1 □ Live birth 2 □ Fet<br>4 □ Pregnant at time of<br>9 □ Unknown   | al death 3                          | ⊒Ectopic pregnanc<br>□ Other <i>(specify)</i> _ | у  |                                       |                                | te of delive                   |   | 'ear                 |
| ords, P  |                   | Part II. Other significant conditions con  | -/   | sulting in the u                    |   | ven in Part I.<br>KL GNG                 | 23e. Did to                           | bacco use cont<br>es 2 1 No    |                                | ne cause of de<br>pably 4 ∐U  |                      |
| al Records,  The law requires to take has been signer; page 2 should be of   | Completed by      |  |  |                                     |   |  | 24a. Was a autop perfor 1 Yes         | sy<br>med?                     | prior to co<br>d <u>ea</u> th? | psy findings a<br>mpletion of ca<br>2 \(\frac{1}{2}\)\(\frac{1}{2}\)\(\frac{1}{2}\) | available<br>ause of |
| Vitasiciar<br>siciar<br>certif   | Be                | 25. Was case referred to medical examiner?   | ospital:   |                                     | Ott   | or:                                      | ath (Check only or                    |                                |                                |   |                      |
| Or<br>Phys   | <u>۲</u>          | 1 ☐ Yes 2 No ☐ ☐ 27. Manner of Death   | 1 ☐ Inpatient 2 ☐<br>28a. Date of Injury   | ER/Outpatier<br>28b. Time o         | IL SIL DOA                                      | 4 LI Nursing F                           | lome 5 Resid                          |                                |                                | y)  |                      |
| Division or Vital I or Attending Physician:  after death. I Director: After this certifical d in by the funeral director, p  | Certification:    | 1 Natural 5 ☐ Pending investigation 3 ☐ Suicide 6 ☐ Could not be   | (Month, Day Year)  28e. Place of injury - At h   | Injury                              | M 1   | rk?<br> Yes 2 □ No                       | 28f. Location (S                      |                                |                                | al Route Numb   | her.                 |
| Div  | erti              | 4 ☐ Homicide determined  | building, etc. (Spec   | fy)                                 | ,,  |  | City or Tow                           |                                |                                |   | -                    |
| Division or Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page. | Medical C         | 29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin   | ician: To the best of my kn er: On the basis of examin and manner stated.  | owledge, deat<br>ation and/or in    | h occurred at the ti                            | me, date and place<br>opinion, death occ | e, and due to the ourred at the time, | cause(s) and madate and place, | anner as s<br>and due t        | tated.<br>the cause(s)  | )                    |
| To the within To the Comp  | ğ                 | 29b. Signature and title of certifier  | 2000   | us,                                 | 29c. Licens                                     | se number                                | 2                                     | 29d. Date signe                | d (Month,                      | Day, Year)  | _                    |
| 7  | 1                 | 30. Name and address of person who cor   | nnleted cause of death (Ite  | m 23a) /Tyne                        | Print)  | 0.000                                    |                                       |                                | . ,                            | , ,   |                      |

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| IK ONK  |                | 1- For State Certificate of Dea  |   |                                   | cto /  | in the fire                |
|---|----------------|--|---|-----------------------------------|--|----------------------------|
| Physicia  |                | Registrar  | 2, [  | Reg. No                           |  | 3. Time of Death           |
| edical Exami  | ner            | Coscilia Military  |   | Month Da<br>Jugust 8, 200         | 07   | 0145 hrs                   |
| )   |                |  | y, Town, or Location of Death<br>timore   |                                   | 4c. County of Death                                |                            |
| Funeral<br>Director   |                | 214-92.5613 12M 2 F 29 Yrs. Mor  | nder 1 Year If Under 24Hrs. 8. nths Days Hours Min.                                 | Date of Birth(N                   | 78 P. Birth<br>Foreign<br>Cou                      |                            |
| any   |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |   |                                   |  | 10d. Inside City Limits    |
| nd<br>show :  | _              | MD Baltimor  | -e  |                                   |  | 1 Yes 2 No                 |
| Maryla<br>28a-f<br>d at o   | Director       | 10e. Street and Number 10f. 2  | Zip Code  | 10g.                              | Citizen of What Coun                               | ry?                        |
| th the 1<br>23a or<br>10tifie   | ä              | 3036 May held Ave  | 21213   |                                   | USA  | <u> </u>                   |
| imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.  | Funeral        |  | edent of Hispanic Origin? (Specify ecify Cuban, Mexican, Puerto Rica  2 No specify: |                                   | 14. Race - Americ<br>White, etc.                   | an Indian, Black,          |
| ours afi<br>atural  | d by           | or Dates:  | al Occupation (Give kind of work  | done 16                           | b. Kind of Business/In                             |                            |
| 6<br>n 72 hc<br>isan "na<br>ical Es   | Completed      | Elementary/Secondary (0-12) College (1-4 or 5+)  | working life. DO NOT use retired)   |                                   | a  |                            |
| -003<br>withingiene.  | om             | 17. Father's Name (First, Middle, Last)  | Service<br>18.Mother's Name (Firs   |                                   | SO I   |                            |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica  | Be             | Willis Floyd Arrington   | Christin  |                                   | yant   |                            |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.  | ြ              | 19a. Informant's Name/Relationship (Type, Print )  | ess (Street and Number or Rural<br>May field Ave                                    | Route Number                      |  |                            |
| e, MD and 2 sho lealth and item 27 is traumati  |                | 20a. Method of Disposition 20b. Place of Disposition (N  | Name of cemetery, Da  | ate 20                            | 0c. Location - City or 1                           | own, State                 |
| Baltimore, ormit. Pages I ar Department of Hee Important: If ite injury or other tr   |                | 1 Burial 2 Cremation 3 Removal from State crematory or other plan 4 Donation 5 Other Specify:  | se) 8-15-   | -07 E                             | BAltimore  | MB                         |
| Baltimo<br>permit. Page<br>Department of<br>Important:<br>injury or ott   |                |  | nd Address of Facility 2431   | E-Oliv                            | ierst  |                            |
|   | ( )()          | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mod   |   |                                   | Beltimere  | Approximate Interval       |
| Physician<br>/Medical   |                | failure. List only one cause on each line.   | e or dying, such as cardiac or res  | piratory arrest,                  | SHOCK, OF HEAR                                     | Between Onset and<br>Death |
| Examiner  |                | Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):  |   |                                   |  |                            |
|   | Ŀ              | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |   |                                   |  |                            |
|   | Examiner       | cause. Enter Underlying Cause. (Disease or injury that initiated   |   |                                   | 22   |                            |
| ansit   | Exa            | events resulting in death) Last  Due to (or as a consequence of):  d.  |   |                                   |  |                            |
| '60,  cate be executed physician and he burial - transit  | Medical        | UNPENDED AMENDED   |   |                                   |  |                            |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | Physician/Me   |  |   |                                   | 23d. Date of delivery<br>Month Da                  | ay Year                    |
| O. E at the c d by th   |                |  | ing cause given in Part I.  |                                   | cco use contribute to t                            |                            |
| S, P.O.<br>uires that the<br>n signed by<br>id be detach  | ed by          |  |   |                                   | No 3 Proba   | opsy findings available    |
| Vital Records hysician: The law requi this certificate has been I director, page 2 should   | Completed      |  |   | 24a. Was an autopsy performed     | prior to co  | empletion of cause of      |
| Rec   |                |  | 26.Place of Death (Check only   | 1 ✔ Yes 2                         | No 1 ✓ Yes   | 2 No                       |
| Vital Rec<br>ysician: The<br>his certificate<br>director, page  | Be             |  | DOA Other Nursing Ho  |                                   | sidence 6 Other:                                   |                            |
| of Ving Phy   | n: To          | 27 Manner of Death 28a Date of Injury 28h Time of Injury   |   | I. Describe how<br>piect shot     | injury occurred                                    | · ·                        |
| ttendi<br>death.  | atio           | 1 Natural 5 Pending Pending Investigation Accident Investigation Aug 8, 2007 FOUND:  | 1 Yes 2 V No  |                                   |  | -I D. Ja Marahan Cibe      |
| Divisual or A urs after ral Dire  | Certification: | 3 Suicide 6 Could not be determined (Specify) Local Street   |   | or Town, State                    | et and Number of Rur<br>e)<br>treet, Baltimore, MD | al Route Number, City      |
| Division of <sup>1</sup> To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral  | Medical C      |  | the time, date and place, and due my opinion, death occurred at the                 | to the cause(s)<br>time, date and | ) and manner as state<br>place, and due to the     | d.<br>cause(s)             |
| To Your COTT  | Med            | and manner stated.  29b. Signature and title of certifier  | 29c. License number   | 29                                | d. Date signed (Mon                                | th, Day, Year)             |
|   |                | Donna nu incerti, M.D.   | O.C.M.E.  | A                                 | ugust 9, 2007                                      |                            |
|   |                | 30. Name and address of person who completed cause of death (Item 23a)   | n Street, Baltimore, MD 2   | 21201                             |  |                            |
| \<br>   | ate            |  |   |                                   |  |                            |
| Regist  |                | The state of the s | 2   |                                   |  |                            |
| DHMH 17 Rev 1/2   | 001            | ORIGINAL   |   |                                   |  |                            |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| azel R Beal  |                | State of Maryland / Department of Health and Me  - For State Certificate of Death  |   | 2007 2527  |
|--|----------------|--|---|--|
| Physicia   | _              | Registrar  1. Decedent's Name (First, Middle,Last)   | 2. Date of Death                        |  |
| ledical Examin   |                | Hazel R. Beal  | Month<br>July 28, 20                    | Day Year 1907 hrs  |
|  |                | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 524 N. Charles Street Apartment 1212 Baltimore  | on of Death                             | 4c. County of Death  |
|  | 4              |  | nder 24Hrs. 8. Date of Birth            | n(MM/DD/YYYY) 9. Birthplace (State or                      |
| Funeral<br>Director  |                | 495-38-8485 1 M 2 XF 72 Yrs. Months Days . Hot   |   | Foreign  |
| any.   | 4              | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |   | 10d. Inside City Limits                                    |
| ž .  |                | MD Baltimore   |   | 1 X Yes 2 No   |
| Maryland<br>28a-f show<br>d at once.   | Director       | 10e. Street and Number 10f. Zip Code   | 10                                      | g. Citizen of What Country?                                |
| th the M<br>23a or 2<br>notified   |                | 524 N. Charles Street #1212 21201  |   | USA  |
| AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23s or 28a-f she matic event, the Medical Examiner must be notified at once   | Funeral        | 11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No  13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic   |   | 14. Race - American Indian, Black;<br>White, etc.          |
| after d  | by<br>F        | 3 Widowed 4 Divorced If yes, Give Year of Dates:   | ify:                                    | Specify: white   |
| 5-0036<br>led within 72 hours after<br>Hygiene<br>other than "natural",<br>the Medical Examiner  |                | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Girduring most of working life. DO NO   |   | 16b. Kind of Business/Industry unk                         |
| 36<br>hin 72<br>e<br>than "  | Completed      | Elementary/Secondary (0-12)   College (1-4 or 5+)   College (1-4 o |   |  |
| d withing the the the the the  | 탉              |  | her's Name (First, Middle, M            | laiden Surname)  |
| 215-0036<br>be filed within 7<br>ntal Hygiene<br>rked other than<br>ent, the Medica  | )<br>B         | Nineveh Jackson Beal Ha  | azel Leona Co                           | pling  |
| Baltimore, MD 21215-00 pernit. Pages I and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Market and the Market of the Injury or other traumatic event, the Market and Item Market an | 의              | 19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and N  |   |  |
| MD and 2 sho saith and 2 sho saith and sem 27 is raumati   | -              | O.C.M.E. 111 Penn Street  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,  |   | MD 21201  20c. Location - City or Town, State              |
| Ore<br>ges 1 a<br>of He<br>If ite  |                | 1 Burial 2 Cremation 3 Removal from State crematory or other place)  | Bate                                    | 200. Education Oily of Form, oldico                        |
| Baltimore,<br>permit. Pages I an<br>Department of Hea<br>Important: If iter  | -              | 4 X Donation 5 Other Specify:  | Cility                                  | -  |
| Bal<br>perm<br>Depa<br>Impo  |                |  |   | Baltimore Street   |
| Physician  | +              | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a failure. List only one cause on each line.  | 21201<br>as cardiac or respiratory arre | st, shock, or heart Approximate Interval Between Onset and |
| /Medical<br>Examiner   | 1              | Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease   |   | Death  |
| -Xanimiei  | -              | or condition resulting in death)  Due to (or as a consequence of):   |   |  |
|  | ا ة            | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |   |  |
|  | Examiner       | cause. Enter Unidenying Cause (Disease or injury that initiated  |   |  |
| ted<br>I<br>Insit  |                | events resulting in death) Last Due to (or as a consequence of):   |   |  |
| execu<br>ian and<br>al - tra   | Medical        | UNPENDED AMENDED   |   |  |
| ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed teath.  for: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transit  | 좕              | IF FEMALE: 23c. If yes, outcome of pregnancy   |   | 23d. Date of delivery                                      |
| Box 687, death certificate at the death certificate at the direction of the death of the death d | Physician/     | past 12 months?  | opic pregnancy                          | Month Day Year   |
| Sox<br>Jeath of<br>e atter   | ysic           | 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown   |   |  |
| that the d   | F.             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in   | n Part I. 23e. Did tol                  | bacco use contribute to the cause of death?                |
| ords, P.O. I   | d b            |  | 1 Yes                                   | 2 No 3 Probably 4 Unknown                                  |
| ords<br>aw requir  | ete            |  | 24a. Was a autops                       |  |
| Recol<br>The law<br>icate has  | Completed by   |  | perform<br>1 <b>V</b> Yes 2             |  |
| of Vital Records, ng Physician: The law requir Mer this certificate has been is neral director, page 2 should t  | Bec            |  | ath (Check only one)                    |  |
| of Viting Physic   | 인              | 1 Yes 2 No Tospital 1 Inpatient 2 ER/Outpatient 3 DOA  |   | Residence 6 🗸 Other: Scene                                 |
| n of ding Ph   |                | 27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at W 1 Yes 2  |   | now injury occurred  |
| Division al or Attendi rs after death al Director; led in by the ft  | cati           | 2 Accident Investigation 28e Place of Injury - At home farm street factory office building   |   | Street and Number or Rural Route Number, City              |
| Divisi<br>pital or Att<br>ours after d<br>neral Direct<br>filled in by   | Certification: | 3 Suicide 6 Could not be determined (Specify)  | or Town, St                             |  |
| Hospi<br>24 hou<br>Funer<br>tely fil   |                | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and   |   |  |
| Division To the Hospital or Attenti within 24 hours after death To the Fineral Director: , completely filled in by the fi  | Medical        | Medical Examiner:On the basis of examination and/or investigation, in my opinion, death<br>and manner stated.  |   |  |
| FSFO   | ž              | 29b Signature and title of certifier 29c. License numb   | per                                     | 29d. Date signed (Month, Day, Year)                        |
|  |                | (Canterley) O.C.M.E.   |   | July 29, 2007  |
|  |                | So Mame and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore,  | MD 21201                                |  |
| Sta  | ot o           | 31. Date filed (Month, Day Year) 32. Registrar's Signature   | WD Z 1ZU I                              |  |
| Regist   |                | AUG 1 6 2007 Blown & Specie  |   |  |
| DHMH 17 Rev 1/20   | 01             | OCME   |   |  |

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Division or Vital Records, P.O. Box 68760, physician attending ò signed by certificate this After 1 after death Director: 24 hours a within 2

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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Examine

Physician/Medical

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Completed

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Certification: To

Medical

State

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** 

Baltimore, Maryland 21215-0036

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D40324 JULY 30, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 SURRAITS ROAD, CLINTON, MARYLAND 20735 TERRY JODRIE, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001

|  |  |                | 1 = For<br>State<br>Registrar   | State of Mar                                    |                                   | artment of H<br>Hificate of L             |                     |                                      | CUL                      |                          | 25273   |
|--|--|----------------|---|---|-----------------------------------|---|---------------------|--------------------------------------|--------------------------|--------------------------|---|
|  |  | -              | 1. Decedent's Name (First, Middle, Las  | )   | 067                               | incate of L                               | Jeani               | 2. Date of Death                     | g. No.                   |                          | 3. Time of Death                              |
|  | Physici  |                | Gladys Elizabeth  |   |                                   |   |                     | Month                                | Day                      | Year<br>O.7              | 00:17 A M                                     |
|  | /Medio<br>Examin   |                | 4a. Facility Name (If not institution, give   |   |                                   | 4b. City. Town, or                        | Location of Death   | August                               | 10 , 20<br>4c. County of |                          | 00:17 A                                       |
|  | CXAIIIII   | EI             | Harford Memorial  |   |                                   | Havre d                                   | le Grace            |                                      | Har                      | ford                     |   |
|  | Funeral  |                | 5. Social Security Number 6. Se   |   | In yrs. last birthday)            | If Under 1 Year                           | If Under 24 Hrs.    | 8. Date of Birth<br>(Month, Day,     |                          |                          | ace (State or Foreign                         |
|  | Director   |                | 230-26-3765   | ]M 2⊠F  | 82 Yrs.                           | Months Days                               | Hours Min.          | Sep. 4.                              |                          |                          | inia  |
|  | <u> </u>   |                | Usual Residence of Decedent   |   |                                   |   |                     |                                      |                          |                          |   |
|  | ahow   | بيد            | 10a. State 10b. County  | 1   | 0c. City, Town or Lo              | cation                                    |                     |                                      |                          | 10                       | d. Inside City Limits 1 ☐ Yes 2 ☑ No          |
|  | Ba-f   | cto            | Maryland Cecil  |   | Cono                              | wingo                                     |                     |                                      | - 1                      |                          |   |
|  | vith th  | Director       | 10e. Street and Number  |   |                                   | 10f. Zip Code                             | -                   | 10                                   | g. Citizen of W          | hat Count                | ry?   |
|  | ours after death with the Maryla<br>ral', or Items 23a or 28a-f shov<br>Exa ulnet is ust be netified at  |                | 1608 Doctor Jack  |   |                                   | 2191                                      |                     |                                      | USA                      | America                  | o Indian                                      |
|  | er de<br>Item  | Funerai        | 11. Marital Status  | 12. Was Decedent Eve<br>Armed Forces?           | er in U.S. 13. \                  | Was Decedent of Hi<br>f Yes, specify Cuba | n, Mexican, Puerto  | ecity Yes or No-<br>Rican, etc.)     |                          | - America<br>c, White, e |   |
| 36   | rs aft   | by F           | 1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2X No<br>If Yes, Give<br>Year or Dates: | li li                             | 1 ☐ Yes 2 <b>%</b> ☐ No                   | Specify:            |                                      | Specify:                 | Whi                      | +0  |
| 21215-0036   |  | ed             | 15. Decedent's Ed   |   | 16a. Dece                         | dent's Usual Occupa                       | ation               | 1                                    | 6b. Kind of Bus          |                          |   |
| 15   | n "n   | Completed      | (Specify only highest grad  | le completed)                                   | (Give                             | kind of work done o<br>DO NOT use retired | turing most of work | ing                                  |                          |                          | ,   |
| 212  | iene.  | mo             | Elementary/Secondary (0-12)   | College (1-4or 5+)                              |                                   | Homemaker                                 | •                   |                                      | Own :                    | Home                     |   |
|  | Hygid<br>other   | a)             | 17. Father's Name (First, Middle, Last)   |   |                                   |   | 18. Mother's Name   | e (First, Middle, M                  |                          |                          |   |
| lar  | Menta<br>Menta<br>rked   | ToB            | Courtland Meridit   | h Morrisse                                      | tte                               |   | Surrende            | er Louise                            | e Snell                  | ings                     |   |
| Maryland   | s 1 and 2 should be filed within 72 hc<br>f Health and Mental Hygiene.<br>Item 27 is marked other than "natu<br>other traumatic event, the Madical | Ţ.             | 19a. Informant's Name/Relationship (7   | /pe, Print)                                     | 19b. Mailir                       | ng Address (Street a                      | and Number or Rura  | al Route Number,                     | City or Town, S          | State, Zip               | Code)   |
|  | 1 and 2<br>Health a<br>em 27 is  | ή,             | Patricia L. Parks   | /Daughter                                       | 160                               | 8 Doctor                                  | Jack Road           | d. Conowi                            | ingo, M                  | D 219                    | 18  |
| J.   | of Heal  |                | 20a. Method of Disposition  |   | 20b. Place of Dispo               | sition (Name of<br>natory or other place  |                     |                                      | Oc. Location - 0         |                          |   |
| E  | Pages<br>nent of the<br>ant: If its<br>ury or of   | Ш.             | 1 ⊠Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify   |   | Bel Air                           | Memorial                                  | Gdn . 8-14          | 4-07 E                               | Bel Air                  | . Mar                    | vland   |
| Baltimore,   | in in the state of   | l i            | 21. Signature of Funeral Service Licen  | 0/ 1  |                                   | Name and Address                          |                     |                                      |                          | # number of the          | 4   |
| m  | Dep<br>Per<br>Per<br>Per<br>Per<br>Per<br>Per<br>Per<br>Per<br>Per<br>Per  | (2) Y          | Stepley al  | Rughs   | 1                                 | 317 Cokes                                 | burv Rd.            | . Abinada                            | on. Mar                  | vland                    | 21009   |
|  |  |                | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only  | lications that caused the                       |                                   |   |                     |                                      |                          |                          | Approximate<br>Interval Between               |
| 1  | Physician  | A.             | Immediate Cause (Final disease or condition   | CATTON  | naria                             | Total                                     | n di                | Seano                                |                          |                          | Onset and Death                               |
|  | /Medical   |                | resulting in death)   | a Due to (or as a c                             | consequence of):                  | 0191                                      | 1 UW                | Juse .                               |                          |                          |   |
|  | Examiner   |                | Conventially list conditions  | Arrenso   | seleinte                          | 7 Court                                   | 1500 7 8 66         | clas to                              | Kens                     | 0                        |   |
| 6  | D ==   | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to or as a c                                | consequance of):                  | 11  | 110                 | , ,                                  | 0                        |                          |   |
| U.   | Cate   | Examin         | Cause (Disease or injury that initiated events  | · Cong  | estino,                           | Henst                                     | Vaile               | NE                                   |                          |                          |   |
| 0,   | be executed<br>sician and<br>burial-transit  | Ä              | resulting in death) Last  | Due to (or as 1 o                               | onsequence of):                   | -4- 5                                     | 1-0                 | _                                    |                          |                          |   |
| 8760,4   | cate be executed<br>physician and<br>the burial-transit  | dical          |   | d. MIVA   | wy Mas                            | a Ma                                      | fulle               | 11                                   |                          |                          |   |
| /W   | entific<br>ing p   | Mec            | IF FEMALE:  |   | y                                 | 1.11.27                                   | 4                   |                                      |                          |                          |   |
| Box  | leath certific<br>attending p  | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome of<br>1 ☐ Live birth 2 {   | Fetal death 3                     | Ectopic pregnancy                         |                     |                                      | 23d. Date<br>Mon         | of deliver               | y<br>Day Year                                 |
|  | the a  | sici           | 1 Yes 2 No  | 4□Pregnant at tin<br>9□Unknown                  | ne of death 5                     | Other (specify)                           |                     |                                      | 131.01                   |                          | July 1021                                     |
| P.0  | that the de<br>ed by the<br>detached   | F              | Part II. Other significant conditions or  | atributing to death but                         | not requiting in the              | ndarkijas asusa suus                      | om in Clorel        | 22a Did tob                          | 2000 1100 000/2          | buta to the              | e cause of death?                             |
| S,   | 8 <u>9</u> 8   | þ              | Part II. Other significant conditions of  | nunbuting to death but i                        | not resulting in the u            | ndenying cause give                       | en in Fanti.        | 1 🗆 Yes                              | 1/                       |                          | ibly 4 Unknown                                |
| or o   | v requii<br>been s<br>should   | ted            |   |   |                                   |   |                     |                                      | 3 2 110                  | 0                        | abiy 4 Golilationii                           |
| Vital Records,                                     | e law<br>has b   | Completed      |   |   |                                   |   |                     | 24a. Was an autopsy                  | / / p                    | rior to com              | sy findings available<br>apletion of cause of |
| H  | : The l<br>cate ha   | ပ္ပ            |   |   |                                   |   |                     | perform<br>1 Yes 2                   | No 1                     | eath?                    | 2 🗆 No  |
| ) <del>=</del> =================================== | Attanding Physician: Thir death. sctor: After this certificate by the funeral director, pag  | Be             | 25. Was case referred to medical examiner?  | Joseph 1  |                                   | 1.0%                                      |                     | h Check only one                     | )                        |                          |   |
| To   | Physic<br>this d   | To             | 10 195 2040   | Hospital: 1 Tripatient                          | 2 ER/Outpatier                    |   | 4   Nursing no      | me 5 Resider                         |                          |                          | )   |
| Ĕ  | ding Ph<br>h.<br>After th<br>funeral   | io             | 27. Mann of Death 1 Statural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Y            | 'ear) 28b. Time of Injury         | Worl                                      |                     | 28d. Describe how                    | w injury occurre         | 90                       |   |
| Si   | death<br>death<br>ctor: /<br>/ the fu  | icat           | 2 Accident investigation 3 Suicide 6 Could not be   | OD - Disea of Initial                           | . At hamp form at                 |   | Yes 2□No            | OPf Location /Ctr                    | not and Number           | or or Oural              | Pouto Number                                  |
| Division   | i Fire   | Certification: | 4 Homicide determined   | building, etc. (                                | · At home, farm, str<br>(Specify) | eet, factory, office                      |                     | 28f. Location (Str.<br>City or Town, | , State)                 | or nurar                 | Houle Namber,                                 |
|  | To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by   |                | 29a. Certifier 1 Certifying Ph  | sician: To the best of r                        | my knowledge deat                 | h occurred at the tim                     | ne date and place   | and due to the ca                    | use/s) and mar           | nner as sta              | ated  |
|  | Hos<br>24 h<br>Fun<br>Fun  | Medicai        | (Check only 2 Medical Examone)  | iner: On the basis of example and manner state  | kamination and/or in              | vestigation, in my of                     | pinion, death occur | red at the time, da                  | te and place, a          | nd due to                | the cause(s)                                  |
|  | ithin<br>o tha   | ₹<br>S         | 29b. Signature and title of certifier   |   |                                   | 29c. License                              | e number            | , 29                                 | d. Date signed           | (Month, L                | Day, Year)                                    |
|  | - s - 3  |                | ) In  | 116   |                                   | 10-                                       | 2016/               |                                      | 0                        | 10.                      | 957   |
|  | -  |                | 30. Name and address of person who  | ompleted cause of dea                           | th (Item 23e) (Type               | Print)                                    | 200                 | 1                                    |                          | 1-1                      | 0/  |
|  | 3  | -              | 5 1 - 1 00 M  | 12-66   | ROITE                             | Pution                                    | u St k              | tauro 1                              | to Fr                    | ace                      | MO  |
| Q.   | € Sta  | te             | 31. Date liled (Month, Days Year)   | 32. Registrar's                                 | Signature                         | N.  | The Lot             | , , , ,                              | 7                        | -                        | 1078  |
| *  | Registi  |                | AUG 1 6 200   | of the same                                     | B. Ago                            | W.  |                     |                                      |                          |                          | 0-10  |
|  |  | -              |   |   |                                   |   |                     |                                      |                          |                          |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DYDD 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner nklir QL 8. Date of Birth (Month, Day, Year) 6. Sex If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (in yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 1 XM 2 □ F Months Days Hours 60 212-48-6545 Director MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show is marked other must be notified at 10b. County 10d. Inside City Limits MD BALTIMORE ROSEDALE 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7927 UNDERHILL ROAD 21237 U.S.A. Funeral 72 hours after death 12. Was Decedent Ever in U.S. 1
Armed Forces?
1 ☐ Xes 2 ☐ No
If Yes, Give
Year or Dates: VIETNAM 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 9 3 ☐ Widowed 4 ☐ Divorced WHITE Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) SHIP REPAIR MARINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) RUSSELL ALLEN BROOKS, SR. DOROTHY (DAVIS) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17363 19a. Informant's Name/Relationship (Type. Print) SON RUSSELL A. BROOKS, III. 6001 HYSON MILL ROAD STEWARTSTOWN, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or or ö 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-15-2007 CATONSVILLE, MD METRO CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 21237 ROSEDALE, MD Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arteniosclero resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical as the l attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform 2 No 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2□ No 2 ER/Outpatient 3 DOA 2 1 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and fitle of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

DHMH 17 Rev 1/2001

Trimble

H:II

Luther: 11

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Bieller 6:05 AM John Η. 2007 AUGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A Union Memorial Hospital Baltimore Months Days Hours Min. April 24, 1937 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 X M 2 □ F Mary land 70 214-34-4063 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show 1 X Yes 2 □ No be notified Director Md. N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2! any hijury or other traumatic event, the Micdical Examiner must be no once. 21225 11 Rene Ave. USA by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify White Specify. 3 ☐ Widowed 4 N Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Machining 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Sandige George Bieller ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12806 Manor Rd. Glen Arm, Md. 21057 Ms. Jane Baumer/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Hilltop Service Co. 8-16-07 Towson, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Fareral Service License Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. disease Immediate Cause (Final disease or condition resulting in death) Acute exacuerbation of obstructive pulmonary 10 days **Physician** /Medical Due to (or as a consequence of): Examiner Chronic obstructive pulmonary disease 30 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT 2438946-H13 August 14, 2007 1 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Union Memorial Hospital Balt, MD SHEPP Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 5:08 A.M Phyllis Brocato-Lambert Joan tugust 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, May 8, 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Months 1□M 21 F 68 234-56-2365 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 🖾 es 2 🗆 No Maryland N/A Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 USA 712 Primson Avenue Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or Iter 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Scrap Metal Company Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elliott ပ Harry Hizer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an item 27 i Thurman N. Lambert (Husband) 712 Primson Avenue. Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State 8/16/07 Baltimore, Maryland Loudon Park Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Lice 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part From the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Inknown Cornan Arterio sclentic
Due to (or as a consequence of): Vasevier Physician /Medical Examiner Sequentially list conditions, Due to (or as a consequence of): Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed for use as the burial-tra Due to (or as a consequence of): 68760 Box IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 Ø No 4 Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No ty pertension 24a. Was an has autopsy performed/ page 1∐ Yes 2 No long Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Yes 2 No ō 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? funeral 27. Manner of Death Certification: 5 Pending investigation the Hospital or Attending I Division 1 Natural within 24 hours are to to the Funeral Director: Aft 1 Yes 2 No Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

6 2007

5

29c. License number

900 Caton Avene

29d. Date signed (Month, Day, Year)

and manner stated.

Agres 1/05 32. Registrar's Signature

Hospita

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

07-06000

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| 0<br>Central  | 1-                                  | Please Type or Print in Black Inde<br>State of Maryland / Departr<br>For State Certifi  | ment of Health and Menticipate of Death  | al Hygiene  Reg. No.   | 2tt 7 252   |
|---|-------------------------------------|---|--|--|---|
| Physicia<br>I Examin  | n/ <sup>1</sup><br>er               | egistrar Decedent's Name (First, Middle,Last)  Elnora  a. Facility Name (if not institution, give street and number)  | Central 4b. City, Town, or Location of   | 2. Date of Death  Month Day Ye  August 5, 2007   | aar 3. Time of Death<br>1346 hrs  |
| uneral  |                                     | 2643 Kennedy Avenue Apt. # 1  5. Social Security Number 6. Sex 7. Age (In yrs. last 216–24–2306 1 M % F 80  | birthday)  Yrs.  Baltimore  If Under 1 Year   If Under  Months   Days   Hours  | 24Hrs. 8. Date of Birth(MM/DD/YY) Min. 05 30 27  | Country) VA   |
| permit. Pages I and 2 should be filed within 72 hours atter death with the Maryland. Department of Health and Mental Hygin and Department of Health and Mental Hygin and Important: If then 2.7 is marked other than "natural", or items 23a or 28a-f show any Important: If then 2.7 is marked other than "marked other transmatic event, the Medical Examiner must be notified at once. | To Be Completed by Funeral Director | MD  NA  Beauties  2643 Kennedy Ave Apt #1  11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced of Dates  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  12th qrade  17. Father's Name (First, Middle, Last)  Bernie Allen  19a. Informant's Name/Relationship (Type, Print)  Dianna Allen-Niece  20a. Method of Disposition  1 Versial 2 Cremation 3 Removal from State | 19b. Mailing Address (Street and Nur 1055 West Lex ace of Disposition (Name of cemetery, ematory or other place) t. Auburn  22. Name and Address of Facility  As Con For House   | in? (Specify Yes or No-Puerto Rican, etc.)  14. Ra Will Specify Kind of work done use retired)  16b. Kind of Sill Sill Shame (First, Middle, Maiden Surnar Act Cousins and Cousins and Cousins of Rural Route Number, City or Tington St., Ba Date  18/15/2007 Bal | ce - American Indian, Black, nite, etc.  y: Black Business/Industry  oer's Bakery me)  own, State, Zip Code) 2 1223 1 timore, Md on - City or Town, State  timore, Md |
| re death certificate be executed the attending physician and red for use as the burial - transit  | Medic                               | or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  LINDENDED  IF FEMALE:  23b. Was decedent pregnant in the  | ardiovascular disease  : : : : : : : : : : : : : : : : : :   |  | Death te of delivery  |
| The law requires that the death certific freate has been signed by the attending I, page 2 should be detached for use as the  | Completed by Physicia               | 1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not re  | esulting in the underlying cause given in  | 1 Yes 2 No   | contribute to the cause of death?  3 Probably 4 Unknown  24b. Were autopsy findings availabe prior to completion of cause of death?  1 Yes 2 No                       |
| To the Inospiral or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and comminete filled in two the funeral director, page 2 should be detached for use as the burial - transit   | Medical Certification: To Be (      | 25. Was case referred to friends a examiner?  1  Yes 2 No  27. Manner of Death 1  Natural 5 Pending 2  Accident Investigation 3  Suicide 6  Could not be determined (Specify)  29a. Certifier 1  Certifying Physician: To the best of my knowled one) 2  Medical Examiner: On the basis of examination a and manner stated.   | ER/Outpatient 3 DOA Other, 28b. Time of Injury 28c. Injury at W 1 Yes 2 ome, farm, street, factory, office building, 29c, death occurred at the time, date and and/or investigation, in my opinion, death 29c. License number 29c. License number 29c. | Nursing Home 5 Residence ork? 28d. Describe how injury or No etc. 28f. Location (Street and Nor Town, State)  place, and due to the cause(s) and moccurred at the time, date and place, over 29d. Date   | Number or Rural Route Number, Ci  |
| F > F 0   | -                                   | land Jeg ans  | O.C.M.E.   | 1.1.325  |   |

DHMH 17 Rev 1/2001 OCME 2006

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Raymond Campbel   | 1- For State  | State of Marylan   | d / Department of<br>Certificate of | Health and Mental H<br>Death  |  | . No.   | d 2627                    |
|---|---|--|-------------------------------------|---|--|---|---------------------------|
| Physician/  | Registrar  1. Decedent's Name (First, M                       | liddle,Last)   |                                     |   | 2. Date of Death                           |   | 3. Time of Death          |
| Medical Examiner  |   |  |                                     |   |  | Day Year<br>07                                    | 1027 hrs                  |
| `   | 4a. Facility Name (if not instit                              |  | per)                                | b. City, Town, or Location of Death Baltimore                               | 1  | 4c. County of Death                               |                           |
| Funeral   | 5. Social Security Number U                                   | n k <sup>6. Sex</sup> 7.   | Age (In yrs. last birthday)         | If Under 1 Year If Under 24Hr   | _  | (MM/DD/YYYY) 9. Bir<br>Foreig                     | thptace (State or unk     |
| Director  | T X 3   | 1XM 2F   | 54 Yrs                              | Months Days Hours Mir   | Sept 2                                     |   | puntry)                   |
|   | Usual Residence of Deceder  10a. State 10b. Cour              |  | 10c. City, Town or Locat            | on  |  |   | 10d. Inside City Limits   |
| <b>*</b> .  | MD  |  | Balti                               | more  |  |   | 1 XYes 2 No               |
| the Maryland to 28a-f. shuiffed at once   | 10e. Street and Number  |  |                                     | 10f. Zip Code   | 109  | g. Citizen of What Cou                            | ntry?                     |
| - 25  | 2210 Echodal  |  |                                     | 21214   | 7.3  | USA   |                           |
| death with  | 11. Marital Status 1 Never Married 2                          | Married 12. Was Deced  | 4                                   | s Decedent of Hispanic Origin? (Sees, specify Cuban, Mexican, Puerto        |  | 14. Race - Amer<br>White, etc.                    | ican Indian, Black,       |
| or ite  |   | 1 Yes Divorced If Yes, Give Year   | 2 No                                | Yes 2X No specify:  |  | Specify: wh:                                      | ite                       |
| numal".   | 3 Widowed 4 15. Decedent's Education (                        | or Dates:  | completed) 16a. Deceder             | t's Usual Occupation (Give kind of  | work done unk                              |   |                           |
| 5<br>72 houn<br>al Exan<br>leted  | Elementary/Secondary (0-                                      |  | during m                            | ost of working life. DO NOT use re  | tired)                                     |   | NA A W PP                 |
| 5-0036 led within 7 Hygiene. I other than the Medica  | unk   | unk  |                                     |   |  |   |                           |
| imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after ment of Health and Mental Hygiene and if free 17 is marked other than "natural", or other trainmatic event, the Medical Examiner To Be Completed by I   | 17. Father's Name (First, Mic                                 | idle, Last)  |                                     | unk 18.Mother's Nam   | e (First, Middle, M                        | aiden Surname)                                    | unk                       |
| 2121<br>mild be fill<br>Mental H<br>marked<br>c event,  | 19a. Informant's Name/Relat                                   | ionship (Type, Print )   | 19b. Mailin                         | Address (Street and Number or   | Rural Route Numb                           | per, City or Town, State                          | e, Zip Code)              |
| MD 2<br>d 2 shou<br>tth and P<br>ii 27 is r<br>funatio  | O.C.M.E.  | (-),-,-,-,   | 111 F                               | enn Street Balt   | imore, M                                   | D 21201   |                           |
|   | 20a. Method of Disposition                                    |  |                                     | ition (Name of cemetery,  | Date                                       | 20c. Location - City or                           | Town, State               |
| Baltimore, permit. Pages I at Department of Hes Important: If ite Important: If ite Injury or other tr  |   | ation 3 Removal from<br>or Sp <i>ecify:</i> in stat  | State                               | not place;  |  |   |                           |
| Baltimo<br>permit. Page<br>Department<br>Importants<br>injury or of   | 21. signation of Funeral Sen                                  | vice Lio   | rector St                           | ame and Address of Facility Boar  | d 655 W.                                   | Baltimore   | Street                    |
| E.E.G.B.M   |   |  |                                     | timore, MD 212 he mode of dying, such as cardiac                            |  |   | Approximate Interval      |
| Physician<br>Medical  | 23a. Part I. Enter the disease<br>failure. List only one ca   | use on each line   |                                     |   |  | st, shock, of fleat                               | Between Onset and Death   |
| xaminer   | Immediate Cause (Final dise<br>or condition resulting in deat | ease a <u>Mixed dru</u><br>th) Due to (or as a c   | intoxication (                      | Amitriptyline and qu  | ietiapine)                                 |   | -                         |
|   | Sequentially list conditions,                                 | b  | 511564251155 41/1                   |   |  |   |                           |
| miner   | if any, leading to immediate cause. Enter Underlying Ca       | Due to (or as a c  | onsequence of):                     |   |  |   |                           |
| me  | Disease or injury that initiate                               | ed C.  | onsequence of):                     |   |  |   |                           |
| executed an and al - transit  |   | d  |                                     |   |  |   |                           |
| O, e be executed ysician and burial - transit   | XUNPENDED   | AMENDED 7  | .28a-f.perME.g870                   | , 8/17/07 TT  |  |   |                           |
| 6876C<br>certificate<br>ading phys<br>se as the b   | IF FEMALE:<br>23b. Was decedent pregnant                      | 23c. If yes, ou  | tcome of pregnancy                  | etal death 3 Ectopic pregr  | nancy                                      | 23d. Date of deliver                              | ry<br>Day Year            |
| OX 68 sath certi  | past 12 months?   | 4 Pregnai  |                                     | ther (Specify)  |  |   |                           |
| . Box 6876C<br>the death certificate<br>by the attending physached for use as the b<br>Physician/Me   | 1 Yes 2 No 9  | Unknown g Unknow   |                                     |   | io Billi                                   |   | the same of death?        |
| that the ned by detach  |   | nditions contributing to   | death but not resulting in the      | underlying cause given in Part I.   |  | 2 No 3 Pro  | bably 4 V Unknown         |
| S, P. uires the uires the did be did |   |  |                                     |   | .   24a. Was a                             |   | utopsy findings available |
| ord<br>aw requas bee<br>as bee  |   |  |                                     |   | autops                                     | sy prior to                                       | completion of cause of    |
| Records, The law require: The tax been sig. page 2 should be Completed  |   |  |                                     | - <u></u>   | 1 ✔ Yes 2                                  |   | es 2 No                   |
| of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by bureral director, page 2 should be detach in: To Be Completed by P.   | 25. Was case referred to me                                   | I I a a side i   | patient 2 🗸 ER/Outpatien            | 26.Place of Death (Check<br>3 DOA Other Nurs                                |  | Residence 6 Other                                 | er:                       |
| Physical dij  | 27 Manner of Death  | 28a. Date o  | f Injury 28b. Time of               | 1 3 DOA 4 Nais  |  | ow injury occurred                                |                           |
| Division of Vital or Attending Phurs after death.  Tal Director: After teled in by the funeral ledd in by the funeral entification: T   | 1 Natural 5   | Pending (Month, I  | Day,Year)                           | 1 Yes 2 X No  | unk  |   |                           |
| Division at or Attending at or Attending and or Attending and Director: And Director: Alled in by the figer at or   | 2 Accident 3 Suicide 6 X                                      |  |                                     | et, factory, office building, etc.  |  |   | tural Route Number, City  |
| Div<br>nital o<br>nurs aft<br>rral D  | 4 Homicide  | determined (Specify)   | found in reside                     | ence  | 2210 Echo                                  | dale Ave. Bal                                     | timore, MD                |
| Division of Vital Records, P.O. Box 68766 To the Itospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Furnarial Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the beneficial Certification: To Be Completed by Physician/Me  | 29a. Certifier 1 Certifyir one) 2 Medical                     | ng Physician: To the best<br>Examiner: On the basis of<br>and manner sta   | examination and/or investiga        | rred at the time, date and place, ar<br>tion, in my opinion, death occurred | nd due to the cause<br>at the time, date a | e(s) and manner as sta<br>and place, and due to t | ted.<br>he cause(s)       |
| T wi  | 29b. Signature and title of ce                                |  | `                                   | 29c. License number   |  | 29d. Date signed (Me                              | onth, Day, Year)          |
|   | Allena 3  | rassell ille   | <del>')_</del>                      | O.C.M.E.  |  | July 30, 2007                                     | <u> </u>                  |
|   | 30. Name and address of pe<br>Melissa Brassell, M             | /fb  |                                     | Penn Street, Baltimore, MI  | 21201                                      |   |                           |
| State   | · · · · · · · · · · · · · · · · · · ·                         | (ear) 32. Reg  | ístrar's Signature                  | 71  |  |   |                           |
| Registra  | 60 A A -  | 1 6 2007   | Contract House                      | neath)  |  |   |                           |
| DHMH 17 Rev 1/2001  |   | and the same of th | ORIGINA                             |   |  |   |                           |

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|            |   |                | For State of Ma  |  | artment of He<br>artificate of D                                      |   |                                     | e-                               | e   | 2007  |            |
|------------|---|----------------|--|--|---|---|-------------------------------------|----------------------------------|---|---|------------|
|            |   |                | Registrar  | Ce   | runcate of D  | ealli                                     | 2. Date of Deat                     | eg. No.                          |   | 3. Time of Death                                      | _          |
|            | Physicia<br>/Medic  |                | 1. Decedent's Name (First, Middle, Last)  1. Decedent's Name (First, Middle, Last)  Cl   | auss   |   |   | ANGELEN!                            | - Day 1t                         | 2007  | 3.44 A M  |            |
|            | Examin  |                | 4a. Facility Name (If not institution, give street and number)   |  | 4b. City, Town, or I  |   | V                                   | 4c. County                       | of Death  |   |            |
|            |   |                | Good Samaritan Hospital  | //p.ura loct hirthdou  |   | imore If Under 24 Hrs.                    | 8. Date of Birth                    |                                  | 9 Birtho  | lace (State or Foreign                                | _          |
|            | Funeral<br>Director   |                | 5. Social Security Number  218-40-4242  6. Sex 1 □ M 2 ☒ F   | e (In yrs. last birthday,<br>65 Yrs.   | Months Days   | Hours Min.                                | (Month, Day,                        | Year)                            | Coun  | try) unk  |            |
| ī          | land<br><b>bw</b><br>it   |                | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or L   | ocation   |   |                                     |                                  | 10  | 0d. Inside City Limits                                |            |
|            | Mary<br>fied a  | 호              | MD   | Balti  | more  |   |                                     |                                  |   | 1 Yes 2 No  |            |
|            | n the   | Director       | 10e. Street and Number   |  | 10f. Zip Code   |   | 1                                   | 0g. Citizen of                   | What Coun                                       | try?  |            |
|            | th wit<br>23a c<br>1st be   | al D           | 4700 Harford Road  |  | -1  | 21214                                     |                                     | 1 11 2                           | USA   | - Indian  | _          |
|            | r dea   | Funeral        | 11. Marital Status unk 12. Was Decedent E Armed Forces?  |  | . Was Decedent of His<br>If Yes, specify Cubar                        | spanic Origin? (Spe<br>n, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)    |                                  | ce - America<br>ck, White,                      |   |            |
| 3          | urs afte<br>al", or It<br>Examin  | þ              | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ N 3 ☐ Widowed 4 ☐ Divorced Year or Dates:  | NO   | 1 ☐ Yes 2 💢 No  | Specify:                                  |                                     | Specif                           | y: whi  | te  |            |
|            | be filed within 72 hours after death with the Maryland at Hygiene.  tal Hygiene.  did Hygiene.  did other than "natural" or Items 23a or 28a-f show event, the Medical Examiner must be notified at   | Completed      | 15. Decedent's Education<br>(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5   | (Give  | edent's Usual Occupa<br>e kind of work done do<br>DO NOT use retired) | tion<br>uring most of work                | <sub>ing</sub> unk                  | 16b. Kind of B                   | usiness/Inc                                     | dustry un   | k          |
| 7 7        | should be filed within od Mental Hygiene. marked other than marle event, the M  |                | unk unk  |  | unk   | 18. Mother's Name                         | e (First. Middle. i                 | Maiden Surna                     |   | unk   | _          |
| 2          | ld be fil<br>ental H<br>ked ott<br>Ic ever  | To Be          | 17. Father's Name (First, Middle, Last)  |  | dik   |   |                                     |                                  |   |   |            |
| <u>a</u>   | 2 should<br>and Mer<br>is marke<br>aumatic  | -              | 19a. Informant's Name/Relationship (Type. Print)   |  | ling Address (Street a  |   |                                     |                                  |   | Code)   |            |
| , <u>×</u> | 127 mg  |                | Good Samaritan Hospital  |  | Loch Rave   |   | altimore                            | 20c. Location                    | 1239<br>- City or To                            | own, State  | _          |
|            | Pages 1 and the sant of Hesant: If item arry or othe  |                | 20a. Method of Disposition  1 □ Bunal 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 🖼 Other (Specify) in state  |  | oosition (Name of<br>ematory or other place                           | 9)  |                                     |                                  |   |   |            |
| Dall       | permit. Pages<br>Department of<br>Important: If it<br>any injury or once.   |                | 21. Signature of Euneral Service Licensee Ronald S. Wade Dir   |  | 22. Name and Address<br>State Anato<br>Saltimore,                     |   |                                     | Baltim                           | ore S   | Street  |            |
| è          | Physician<br>/Medical<br>Examiner   |                |  | the death. Do not energy to th | nter the mode of dying  | g, such as cardiac                        | or respiratory arr                  | rest,                            | u   | Approximate Interval Between Onset and Death Ogg Hoou | 3          |
| ,0070      | The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit  | dical Examiner | Cause. Enter Underlying Cause (Disease or injury that initiated events  c  | a consequence of):   |   |   |                                     |                                  |   |   |            |
| Ò          | ng ph   | Med            | IF FEMALE:   |  |   |   | ****                                |                                  |   |   |            |
| O. DOX     | w requires that the death certific<br>been signed by the attending f<br>should be detached for use as   | ysician/Me     | 23C. If yes, outcome   | 2 Fetal death 3  | Ectopic pregnancy Other (specify)                                     |   |                                     |                                  | ate of delive                                   | Day Year  |            |
| JS, L      | ires that t<br>signed by<br>d be deta   | by Phys        | Part II. Other significant conditions contributing to death b  | ut not resulting in the  | underlying cause give   | en in Part I.                             |                                     | obacco use cor<br>'es 2□ No      |   | he cause of death?                                    | 1          |
| Hecords    | To the Hospital or Attending Physician: The law requ within 24 hours after death.  To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should be a suppletely filled in by the funeral director, page 2 should be a suppletely filled in by the funeral director. | Completed      |  |  |   |   | 24a. Was a autop perfor             | sy                               | . Were auto<br>prior to co<br>death?<br>1 ☐ Yes | opsy findings available impletion of cause of         | ÷          |
|            | an: T<br>lifficate<br>or, pa  |                | 25. Was case referred to medical   |  |   | 26. Place of Dear                         |                                     |                                  | 10100   |   |            |
| >          | yslcia<br>s cer<br>direct   | To Be          | examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie   | ent 2 ER/Outpation   | ent 3 DOA Othe  | er: 4 Nursing H                           | ome 5 Resid                         | lence 6 🗆 Ot                     | ther (Special                                   | fy)   |            |
| o uo       | ding Phy<br>After thi<br>funeral (  |                | 27. Manner of Death  1 Matural 5 □ Pending (Month, Da  2 □ Accident investigation  | ury (28b. Time<br>lnjury   | / Work  | / at<br>⟨?<br>Yes 2 □ No                  | 28d. Describe h                     | now injury occu                  | rred  |   | unk  nk  ? |
| DIVISION   | l or Atten<br>after death<br>Director:  | Certification: | Z Accident   | jury - At home, farm, s<br>tc. (Specify)   | street, factory, office   |   | 28f. Location (S<br>City or Tow     | Street and Num<br>vn, State)     | ber or Rur                                      | al Route Number,                                      |            |
|            | Hospital<br>24 hours<br>Funeral<br>stely filled   | Medical Co     | 29a. Certifier (Check only one)  Certifying Physician: To the best Certifying Physician: To the best and manner st   | of examination and/or  | ath occurred at the tin investigation, in my o                        | ne, date and place<br>pinion, death occu  | , and due to the trred at the time, | cause(s) and n<br>date and place | nanner as s<br>e, and due t                     | stated.<br>to the cause(s)                            |            |
| )          | To the vithin To the comple   | Me             | 29b. Signature and title of certifier  20b. Signature and title of certifier  30. Name and address of person who completed cause of certifier  30. Name and address of person who completed cause of certifier  31. Date filed (Month, Day, Year)  32. Registr | alen'  | 29c. License  | 30661                                     |                                     | 29d. Date sign                   | ed (Month,                                      | Day, Year) th 2007                                    |            |
|            |   |                | 30. Name and address of person who completed cause of c  | death (Item 23a) (Type   | e, Printhalli   | rell.                                     | Kd-                                 | 212                              | 139   | •   |            |
|            | Sta<br>Regist   | ate<br>rar     | 31. Date filed (Month, Day, Year) 32. Registr  | rar's Signature  | parte   |   |                                     |                                  |   |   |            |

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 15 **Physician** ESTHER DAY 12.24AM *Augus*t 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. Coupty of Death 4b. City, Town, or Location of Death Examiner HARBOR HOSPITAL BALTIMORS 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Min 1 M 2 Director Usual Residence of Degedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f shov пs 23a or 28a-f shov must be notified at Director 1 ☐ Yes 2 ZHO Of. Zip Code 10g. Citizen of What Country? 1122 'natural", or Items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whiteneto 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2₽No Completed by Yes. Give Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation Decedent's Education ive kind of work done during most of working fe. DO NOT use retired) (Specify only highest grade completed) ondary (0-12) than College (1-4or 5+) of Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the M 18. Mother's Name (First, Middle, Maiden Be 2 9b. Mailing Address Street permit. Pages:
Department of H
Important: If the
any Injury or ot
once. 3 Removal from State 5 Other (Specify) Sign 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** irrhosis week resulting in death) /Medical Due to (or as a consequence of) **Examiner** SEPSIS 3 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760; Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 ☐ Yes 2 🔀 No 9 ☐ Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has e 2 certificate ha autonsy perform director, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director;
completely filled in by the t 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **RES** 000 MD

State Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year LERO 11:40 AM August 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner BAI+ MOYE

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. MEMorial HOSPHA 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country), 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** 1 M 2 □ F 219-32-1 788 Director MARY Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits if Health and Mental Hygiene. item 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at BAltimorE 1 Ves 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 21215 USA Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes Completed by BIACH 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7. It and Mental Hygiene. 7 is marked other than "ni Elementary/Secondary (0-12) College (1-4or 5+) RINTER 18. Mother's Name (First, Middle, Maiden Surnan 17. Father's Name (First, Middle, Last) J.e., Marylic J.e., armit. Pages 1 and 2 should be be Department of Health and Mer-Important: If item 27 In any injury or other FRENE OW ARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 34+1 S+ NEW PORTNEWS JR lhom43 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Augio, 2007 BAltimore 4 Donation 5 Other (Specify) 22. Name and Address of Facility 2 431 E BA118 M-2/2/3 .WEATHER FORD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Non Small Cell Years /Medical Due to (or as a consequence of): Examiner 1ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Conjestive with resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 Nes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2[VNo 1 Tes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

attending physician and for use as the burial-transit Division or Vital Records, P.O. Box 68760, signed by the at d be detached for this certificate has al director, page 2 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, or Attending

3altimore, Maryland 21215-0036

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

and manner stated. 29c. License number 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address uperson who completed cause of death (Item 23a) (Type, Print)

MD Union Menorial Hospi tal, MD Melanie 31. Date filed (Month, Day, Year)

State Registrar

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Medical

1 6 2007

within 24 hours a To the Funeral I Hospital

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician LORENZO DUPLEE 2007 10:56 PM 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA UMMS Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1₽ M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months **Director** 50 217-66-5199 Usual Residence of Dece 28, 1956 North Carolina permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural" ~-\*\* any injury or other traumatic exercises. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1Y Yes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 954 Forrest St. Funeral USA 14. Race - American Indian, 21202 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Yes 27 No Completed by Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willy Benjamin Can ဥ <u>Helen Gough</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Kent, son 2708 Spelman Rd. Baltimore, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) West Arundel Crematory 08-15- 2007 Odenton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne Opere 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approxim Interval Between Onset and Death Immediate Cause (Final Physician phelimonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and sthe burial-trans tiated events resulting in death) Last Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4☐Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
12 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) 2007 mo M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
CAMOS - JR SOUTH GYELNE ST. BALTIMOYE, MD 21901 31. Date filed (Morting Day, Year); AUG 16 32 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Byron Lamar Dickey State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Rea. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Year Month 2120 hrs Medical Examiner August 12, 2007 Dickey Byron 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital **Baltimore City** 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Months Days Min. Director ·Hours Country) 1X M 2 28 Yrs 09 04 78 MD 216-92-3863 Usual Residence of Decedent any 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show e notified at once. 1 X Yes 2 No 28a-f show Baltimore MD NA death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2141 Hollins Street 21223 U.S.A. Funeral 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes Black Widowed Divorced f Yes, Give Yea Yes 2 X No specify: Specify "natural", à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "mat
injury or other traumatic event, the Medical Exa during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Office Manager na Eagle Messenger 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellison Dickey Gertie Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellison Dickey-Father Jody Knoll Road, Baltimore, Md 21244 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Woodlawn 8/18/07 Baltimore Co, Md Donation 5 Other Specify: 21 Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av Ave, Baltimore, 21215 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Between Onset and /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, Examiner If any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical UNPENDED AMENDED icate has been signed by the attending physician page 2 should be detached for use as the burial -Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Dav Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate 1 🗸 Yes ✓ Yes 2 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other 4 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 V Yes neral Director: After t 28a. Date of Injury (Month, Day, Year) Aug 12, 2007 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot 1612 hrs Natural Yes 2 V No 5 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 2100 Barclay Street, Baltimore City, Md. To the Funeral 4 V Homicide determined (Specify) Local Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) August 13, 2007 O.C.M.E. Donna MU Incontrimo 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

DHMH 17 Rev 1/2001

OCMF 2006

31. Date filed (Month

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State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MARY S. DONALDSON ΪÔ 2ď 9:30A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 417 FOREST VIEW RD. LINTHICUM ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F 217-52-2060 Director 58 4/5/1949 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notifled at Director 1 ☐ Yes 27 No MD ANNE ARUNDEL LINTHICUM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21090 417 FOREST VIEW RD. Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than, Elementary/Secondary (0-12) 1 2 College (1-4or 5+) MANAGER SERVICE STATION permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other: any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARVIN G. DONALDSON 2 DORIS A. SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR. LEONARD LEASURE / HUSBAND 417 FOREST VIEW RD.; LINTHICUM, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State GLEN HÁVEN MEM. PARK 8/15/2007 GLEN BURNIE, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility 1 SECOND AVE. SW SINGLETON FUNERAL HOME; GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIO **Physician** ULMONARY ARREST /Medical Due to (or as a consequence of): Examiner EREBROVASCULAR OCCIDET Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or a a onsequence of): IENSION attending physician and for use as the burial-tran Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: ပ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifica ( leck only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. the Signature ar 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address by person who completed cause of death (Item 23a) (Type, Print) . 4115 Ritche Hwy. Brooklys Park, Md. 21225 ALEGA100 31. Date filed (Month, Day, State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMERIO Of Mary and 7 Department of Health and Mental Hygiene Amerid TTEM/19b, per DVR, C271 9/18/07 WS Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician 9.30 PM 3 08 2007 Audrey Lorraine Fulkoski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lorien Nursing Home Columbia Howard 8. Date of Birth (Month, 146) Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 💥 F Yrs. 216-12-3797 84 Director Jul. <del>19</del>, 1923 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Queen Anne's 1 ☐ Yes 2 ☐ No MD Centreville Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 104 Tighman Avenue 21617 United States by Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 🏋 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail 17. Father's Name (First, Middle, Last)

Albert F. Gordon 18. Mother's Name (First, Middle, Maiden Surname) Mary.T. Hamie M. Ensey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
730 Foxilieadow Lane, Queen Anne, MD 21657 19a. Informant's Name/Relationship (Type. Print) Mildred Boyle - Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Donation 5 Other (Specify) 8-16-2007 Odenton, MD Crematery ame an Address of Facility 21. Sign like | Funeral Service Licens Ambrose Funeral Home, Inc.

1328 SUl phur Spring Rd., Arbutus, MD

21272

Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hort PS71V Physician CONG /Medical Due to (or a consequence of): Examiner fn Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. 25450 NG the attending physician and hed for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🙀 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autonsy performed? 1 Yes 2 No certificate director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After I Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated. 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 063726 MID CREAR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6334

State Registrar MAJERODUNM

6 2007

31. Date filed (Month, Day, Year)

AUG 1

V

DHMH 17 Rev 1/2001

Kunmi mo

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Amend #5 per FH g875 1/08/08 PHF cate of Death

Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** Ferrell 2007 E. 3:50a 13 Esther August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Future Care Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 2117=201 6309 Days **Funeral** Hours 1 □ M 2 🗓 F 79 10 MD Director 2<del>17-55-3096</del> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notifiled at 1 TyYes 2 No Baltimore Director NA MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21207 6728 Wilmont Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □ Yes 🏖 □ No Specify: Specify: Black 3altimore, Maryland 21215-0036 <u>م</u> 3√ Widowed 4 Divorced nd 2 should be filed within 72 hou alth and Mental Hygiene. 27 is marked other than "natura er traumatic event, <u>the Medical E</u> Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education . (Specify only highest grade completed) Ferrell 1 Stop Elementary/Secondary (0-12) College (1-4or 5+) Auto Inc. Owner 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Carter Frank Falstead Department of Health and Important: If item 27 is maany Injury or other traumat 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3412 Croydon Road, Baltimore, Md 21207 Robert Ferrell-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Durial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) King Memorial Park 8/17/07 Randallstown, of Euneral Service License 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENCEPHALOPATHY HNOXIC **Physician** /Medical Due to (or as a consequence of): Examiner PNEUNONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine UERETHTIVE PENSISTENS the death certificate be executed burial-transi and Due to (or as a consequence of): Box 68760 attending physician I.A BE TED Physician/Medical the as 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No P.O. ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ፩ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed HTPOTHYROIDISM RACHESOTON 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? FEEDING TUBE 2 No 2 No 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 ☐ Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely fi 29d, Date signed (Month, Day, Year) 29c. License number title of certifier 29b. Signature and 05056940 2007 AUG ATTENDING 30. Name and address of person who completed cause of death (item 23a) (Type, Print) 22 Athol Ave, Baltimore, Md 21229 James Tansinda, Registrar's Signature State Registrar

|                            |   |                 | For State   | State of Maryla                                     |   | artment of H                              |  | -                                  | giene<br>Reg. No2 |                             | 7/0                                   |
|----------------------------|---|-----------------|---|---|---|---|--|------------------------------------|-------------------|-----------------------------|---------------------------------------|
| S. T.                      |   |                 | Registrar  1. Decedent's Name (First, Middle, Las   | <i>t</i> )  | 007   | - Incare or i                             | Death                                      | 2. Date of De                      |                   |                             | 3. Time of Death                      |
| Ć.                         | Physicia  | an              |   | •   |   |   |  | Month                              | Day               | Year                        | 0925 A N                              |
|                            | /Medic  |                 | LEONARO   | FOOT E  |   | 4h City Town o                            | r Location of Death                        | Au 6vs                             | '                 | 2007<br>ty of Death         | 0923 4                                |
|                            | Examin  | er              | 4a. Facility Name (If not institution, give   | street and number)                                  |   |   |  |                                    |                   |                             |                                       |
|                            | · · · · · · · · · · · · · · · · · · ·   | 15              |   | PITAL   | f-11:44 f- 1  |   | If Under 24 Hrs.                           |                                    |                   | LTIMO                       |                                       |
|                            | Funeral   |                 | Social Security Number     6. S   | БМ 2□Е  | rs. last birthday)<br>Yrs.  | Months Days                               | Hours Min.                                 | 8. Date of Bir<br>(Month, Da       | ay, Year)         | 9. Birth                    | olace (State or Foreig<br>ntry)       |
|                            | Director  |                 | 212-02-1101   | 41  | 115.  |   |  | 11 0                               | 5 65              |                             | MD                                    |
|                            | nd  |                 | Usual Residence of Decedent  10a. State 10b. County   | 100   | City, Town or Lo  | ncation                                   |  |                                    |                   |                             | 10d. Inside City Limits               |
|                            | aryla<br>shov<br>d at   | _               | ,   |   |   |   |  |                                    |                   |                             | 1 MgYes 2 □ No                        |
|                            | Ba-f  | S S             | MD NA   |   | вать  | imore                                     |  |                                    | 40 0'''           | (110)                       | 21                                    |
|                            | ith th  | Director        | 10e. Street and Number  |   |   | 10f. Zip Code                             |  |                                    | 10g. Citizen o    |                             | -                                     |
|                            | th w<br>23a<br>ust t  | <u>a</u>        | 8 Valdivia Ct.  | Apt C   |   |   | 244  |                                    |                   | S.A.                        |                                       |
|                            | r dea   | Funeral         | 11. Maritai Status  | 12. Was Decedent Ever in<br>Armed Forces?           | 1 U.S. 13.  | Was Decedent of H<br>If Yes, specify Cuba | lispanic Origin? (Sp<br>an, Mexican, Puert | pecify Yes or No<br>o Rican, etc.) | )- 14. Ra         | ace - Americ<br>ack, White, |                                       |
| ٥                          | afte<br>or it<br>mlne   |                 | Never Married 2☐ Married  | 1 ☐ Yes 2 ☐ No<br>If Yes, Giva                      |   | 1 ☐ Yes 2 No                              | Specify:                                   |                                    | Spec              | ify: D1                     | .ack                                  |
| 3                          | ours<br>ral",<br>Exa  | 1 by            | 3 Widowed 4 Divorced  | Year or Dates:                                      |   |   |  |                                    |                   |                             |                                       |
| Maryland 21215-0036        | 72 h<br>natu<br>ilcal   | etec            | 15. Decedent's Ed<br>(Specify only highest gra  | lucation<br>de completed)                           | i (Give   | dent's Usual Occup<br>kind of work done   | during most of wor                         | king                               | Balt:             | Business/In<br>LMOLE        | c County                              |
| 7                          | thin<br>an "<br>Me  | du              | Elementary/Secondary (0-12)   | College (1-4or 5+)                                  |   | DO NOT use retired                        | •  |                                    |                   |                             | _                                     |
| 7                          | filed wi<br>Hygier<br>other th  | Completed       | 12th grade  | lyr   |   | Custodia                                  |  |                                    |                   |                             | hools                                 |
| <u> </u>                   | should be filed within 72 hours after death with the Maryland of Mental Hygiene.  Marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marke event, the Medical Examiner must be notified at | Be (            | 17. Father's Name (First, Middle, Last)   | i   |   |   | 18. Mother's Nam                           | , ,                                | •                 | ame)                        |                                       |
| <u>a</u>                   | uld b<br>Ment<br>Irkec  | 2               | Leonard Foote   |   |   |   | Jacquel                                    | ine Gr                             | oss               |                             |                                       |
| =                          | ₹ 5 E E   |                 | 19a. Informant's Name/Relationship (  | Type. Print)  | 19b. Maili  | ng Address (Street                        | and Number or Ru                           | ıral Route Numl                    | er, City or Tow   | n, State, Zij               | o Code)                               |
| Σ                          | permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke any injury or other traumatic once.  |                 | Jacqueline Foo  | te-Mother   | 3629  | ) Vallev                                  | Terrac                                     | e #4,                              | Winson            | r Mil                       | 1, Md 21                              |
| ē                          | oth oth   |                 | 20a. Method of Disposition  | 20  | <ul> <li>Place of Disposition</li> <li>b. Place of Disposition</li> <li>cemetery, cres</li> </ul> | osition (Name of matory or other place    | ce)  | Date                               | 20c. Location     | n - City or T               | own, State                            |
| Ē                          | Page<br>ent c<br>nt: if<br>ny or  |                 | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif   |   |   | emorial                                   |  | 18/07                              | Randa             | allst                       | own, Md                               |
| Baltimore,                 | ortai   |                 | 2). Signa ure p Funeral Service Licer   |   |   | 2. Name and Addre                         | -  |                                    |                   | - 10                        |                                       |
| ñ                          | permi<br>Depa<br>Impo<br>any Ir   | 2               | / > xmnnnn  | U. WALLOWIAN  |   | laren F/<br>1300 Wab                      |  | Del+                               |                   | БМ                          | 21215                                 |
| Ш                          | 70  |                 | 23a. Part . Enter the disease, or com   | plications that caused the d                        | eath. Do not en   | ter the mode of dyir                      | ng, such as cardia                         | or respiratory                     | arrest,           | - 40                        | Approximate                           |
|                            |   |                 | sh Lk, or heart failure. List only one cause on each line.  |   |   |   |  |                                    |                   |                             | Interval Between<br>Onset and Death   |
|                            | Physician /Medical  |                 | Immediate Cause (Final disease or condition esulling in death)  Due to (or as a consequence of):            |   |   |   |  |                                    |                   |                             |                                       |
|                            | Examiner  |                 |   | Due to (or as a cons                                | sequance or):   | • • •                                     | 149  |                                    |                   |                             |                                       |
|                            |   | <u>.</u>        | Sequentially list conditions,   | b. Due to (or as a con-                             | Due to (or as a consequence of):  Due to (or as a consequence of):                                |   |  |                                    |                   |                             |                                       |
|                            | sit sed   | ine             | Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury | 530.10 (6) 40 41 05 110 410 110 1171                |   |   |  |                                    |                   |                             |                                       |
|                            | ecut<br>and<br>tran   | Examiner        | that initiated events<br>resulting in death) Last   | cDue to (or as a con:                               | sequence of):   |   |  |                                    |                   |                             | · · · · · · · · · · · · · · · · · · · |
| 80                         | clan<br>clan<br>ourial  | Ë               |   | 200 10 (01 00 0 001)                                | 304431133 31).  |   |  |                                    |                   |                             |                                       |
| 8760,                      | the death certificate be executed y the attending physician and iched for use as the burial-transit   | dical           |   | d   |   |   |  |                                    |                   | +                           |                                       |
| 9                          | ing p   | Me              | IF FEMALE:  |   |   |   |  |                                    |                   |                             |                                       |
| Box                        | leath certific<br>attending p<br>I for use as   | an/             | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcome pf pre<br>1 ☐ Live birth 2 ☐ F | etai death 3  | ⊒Ectopic pregnanc                         | у  |                                    |                   | Date of deliv<br>Month      | very<br>Day Year                      |
|                            | e des   | by Physician/Me | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4☐ Pregnant at time<br>9☐ Unknown                   | of death 5  | Other (specify) _                         |  |                                    |                   |                             |                                       |
| Р.<br>О.                   | w requires that the d<br>been signed by the<br>should be detached   | Phy             |   |   |   |   | ren in David                               | 220 Did                            | tobacco uso co    | entribute to                | the cause of death?                   |
| Ś                          | The law requires that<br>te has been signed b<br>age 2 should be deta   | b               | Part II. Other significant conditions of  | contributing to death but not                       | resulting in the L  | inderlying cause giv                      | ven in Part I.                             |                                    |                   |                             |                                       |
| ב                          | en si<br>ould   | ed              |   |   |   |   |  | 11_                                | Yes 2 No          | 3 L P10                     | bably 4-10 Unknow                     |
| ပ္က                        | aw re<br>is be<br>2 she   | Completed       |   |   |   |   |  | 24a. Was                           | s an 24l          | b. Were aut                 | opsy findings availab                 |
| ř                          | The law<br>ate has<br>page 2 s  | E 0             |   |   |   |   |  | peri<br>1□ Yes                     | ormed?            | death?<br>1 ☐ Yes           | 2 <b>⊘</b> No                         |
| ta                         |   | Be C            | 25. Was case referred to medical  |   |   |   | 26. Place of Dea                           |                                    | 7.4               |                             |                                       |
| 5                          | Physician: this certific  | To B            | examiner?<br>1 ☐ Yes 2.⊠No  | Hospital:   | 2 ☐ ER/Outpatie   | nt 3 DOA Oth                              | ner: 4 🗆 Nursing F                         | forme 5 ☐ Res                      | sidence 6 🗆 C     | Other (Spec                 | ify)                                  |
| Division or Vital Records, | y Physer this   |                 | 27. Manner of Death   | 28a. Date of Injury                                 | 28b. Time o   |   |  |                                    | how injury occ    |                             |                                       |
| o                          | ding<br>th.<br>tun  | ţ               | 1 XNatural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day Yea                                     | r) Injury   |   | Yes 2∐No                                   |                                    |                   |                             |                                       |
| S                          | Attending<br>r death.<br>ector: After<br>by the fune  | fica            | 3 ☐ Suicide 6 ☐ Could not b   | Zoe. Flace of injury - A                            | At home, farm, st   | treet, factory, office                    |  |                                    |                   | mber or Rui                 | ral Route Number,                     |
| 2                          | lor A<br>after<br>Dire  | Certification:  | 4 Homicide determined   | building, etc. (Sp                                  | ecity)  |   |  | City or 10                         | own, State)       |                             |                                       |
|                            | Hospital 24 hours a Funeral tely filled   |                 | 29a. Certifier 1 2 Certifying Pt  | nysician: To the best of my                         | knowledge, dea  | th occurred at the ti                     | ime, date and place                        | e, and due to the                  | e cause(s) and    | manner as                   | stated.                               |
|                            | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,  | edical          | (Check only 2 Medical Examone)  | miner: On the basis of exar<br>and manner stated.   | nination and/or in  | nvestigation, in my                       | opinion, death occ                         | urred at the time                  | e, date and place | e, and due                  | to the cause(s)                       |
|                            | To the within 2   | Me              | 29b. Signature and title of certifier   |   |   | 29c. Licens                               | se number                                  |                                    | 29d. Date sig     | ned (Month                  | , Day, Year)                          |
|                            | H3F8  |                 | 1   | a. ~  |   | 20.00                                     | 59726                                      |                                    |                   |                             |                                       |
|                            | 1   |                 | Offitz g atri   |   | Itom COal /Time   |   | 59736                                      |                                    | Augu              | 4 15                        | 2007                                  |
|                            | 2   |                 | 30. Name and address of person who  |   |   | 1 =                                       | 11 0                                       |                                    |                   |                             |                                       |
| d                          |   |                 | 31. Date filed (Month, Day, Year)   | 32. Ragistrar's S                                   | ignature  | NOWHWEIT                                  | HOW PITAL                                  |                                    |                   |                             |                                       |
|                            | Sta<br>Regist   | ate<br>rar      | AUG1 6 2  | 32. Registrar's S                                   | H. 6  | barle                                     |  |                                    |                   |                             |                                       |

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** narles arrison 08 2130 0 2007 /Medical 4b. City, Town, or Location of Death Sculis bury 4c. County of Death Facility Name (If not institution, give street and number, Examiner Hospice at the Wicomico ake If Under 1 Year If Under 24 Hrs. Hours Min. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Y Sept 30, 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days 1 M 2 □ F 1941 Washington DC 65 Director 189-32-1538 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director MD Worcester Stockton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1544 Snow Hill Road 21864 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk College (1-4or 5+) Elementary/Secondary (0-12) **12** secretarial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pauline Wilson Elliott Earl Burdette Garrison ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 351 Deershead Hospital Road Salisbury, MD 21801 Coastal Hospice at the Lake 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signal proof Funeral Septice Licensee Ronald S. Wade 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street no Baltimore, MD 23a. Pak1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sept **Physician** REMIX /Medical Due to ( as a consequence of): Ular Examiner ccebit4 Sequentially list conditions, or as a consequence of) Examiner if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed and Due to (or as a consequence of) burial-P.O. Box 68760, physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2[**N**0 cate has been sig , page 2 should b 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Yes 2 certificate l 1□ Yes Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA ို this 27. Manner of Feath 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 200,5 Year) 32 Registrar's Sig State 6 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland, Department of Health and Mental Hygiene 1- State Registrar Amend 24a, perMD, g870, 8/16/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 0426 AM LLEA MARGARE ,200 tugust /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Dit el Bultryore Ba Hmore If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. Jast birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 K F 12-19019 Director TULY Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 X Yes 2 No Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Roy "natural", or items 23a or dical Examiner must be Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🏹 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Completed by 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL DE 12 HIGRADE 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be old be f NDREU 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 60 AVE HNDRE GREEN TIMORE MD 21201 other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) Date Chang 20a. Method of Disposition 20c. Location - City of Town, Stat Pages ŏ 1 Borial 2 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) = 5 3 ☐Removal from State Department of Important: If any Injury or once. 8-17-07 **Metro Crenatory** Baltimore, Mil. JR. FUNERAL HOME 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN war FULTON Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory Immediate Cause (Final disease or condition resulting in death) **Physician** 40 cardiol aute /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine certificate be executed sician and burial-tran Due to (or as a consequence of) Physician/Medical the as IF FEMALE esn 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months
1 ☐ Yes 2 ☐ No for Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached o. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes Vital Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical exampler?
11/2/Yes 2/2-No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA ٩ 1 Inpatient ō 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: To the Hospital or Attending 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8-13-07 -16090 of deathr(Item 23a) (Type, Print) 2700 QUARA; Lake DR. BALTO. Md. 21209 31. Date filed (Month, Day, Year) 32 Registrar's Signature State DEALL! AUG 1 6 2007 Registrar 9 845 al

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2007 1855 hrisoul /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Glen Burnie 309 First Ave SW Social Security Number Anne Arundel If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2XXF Director Aug 1, 1921 MD 86 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show iral", or items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21061 Funeral <u>USA</u> 309 First Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XX No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify Š 3 ☐ Widowed 4 ☑ Divorced WHITE "natural" Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Packer Pharmaceutical 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philip Economy Laura Moynagh မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terrence Gallager SON 216 Greenway SE, Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1√X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Hayen Cemetery Aug 15, 2007 Glen Burnie, MD 21. Signature 22. Name and Address of Facility Fink Funeral Home, P.A. 426 Crain Hwy s, Glen Burnie, MD 23a. Part1. Enter the disc a shock, or heart failule. Immediate Cause (Final disease or condition resulting in death) ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death **Physician** erios 15CASA /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of) Be Completed by Physician/Medical attending p for use as as has certificate ha Medical Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 within 24 hours after death To the Funeral Director: completely filled in by the

| IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 ☑ No<br>9 □ Unknown |               | 23c. If yes, outcome pf pregn<br>1 ☐ Live birth 2 ☐ Fet<br>4 ☐ Pregnant at time of a<br>9 ☐ Unknown | al death 3 □E                       |          | pregnancy<br>(specify)       |                                |   | 23d. Date<br>Mor             | e of delivery<br>oth Day                           | Year                                   |
|---|---------------|---|-------------------------------------|----------|------------------------------|--------------------------------|---|------------------------------|--|--|
| Part II. Other significant conditio   | ons co        | ontributing to death but not res  | ulting in the und                   | lerlying | g cause given in             | Part I.                        | 23e. Did tobacc                                     |                              | bute to the ca                                     | 4.1                                    |
|   |               |   |                                     |          |                              |                                | 24a. Was an autopsy performed                       | ?   d                        | Vere autopsy<br>rior to comple<br>eath?<br>□Yes 2□ | findings available<br>tion of cause of |
| 25. Was case referred to medical  |               |   |                                     |          | 26.                          | Place of De                    | eath (Check only one)                               |                              |  |  |
| examiner?<br>1AYes 2□ No  |               | Hospital: 1 ☐ Inpatient 2 ☐   | ER/Outpatient                       | 3 🗆      | DOA Other:                   | □ Nursing                      | Home 5 Residence                                    | e 6 □Othe                    | er (Specify)                                       |  |
| 27. Manner of Death  1 X Natural 5 ☐ Pending 2 ☐ Accident investig                                  | ation         |   | 28b. Time of<br>Injury              | М        | 28c. Injury at Work? 1 ☐ Yes | 2 🗆 No                         | 28d. Describe how in                                | njury occurre                | ed   |  |
| 3 Suicide 6 Could n<br>4 Homicide determin  |               | 28e. Place of injury - At h<br>building, etc. (Speci  | ome, farm, stree<br>fy)             | et, fact | ory, office                  |                                | 28f. Location (Street<br>City or Town, St           | and Numbe<br>tate)           | er or Rural Ro                                     | ute Number,                            |
| 29a. Certifier 1 Certifying (Check only one)  | g Phy<br>Exam | ysician: To the best of my kno<br>siner: On the basis of examina<br>and manner stated.              | owledge, death<br>ation and/or inve | occurr   | ed at the time, o            | late and place<br>on, death oc | ce, and due to the caus<br>curred at the time, date | e(s) and mar<br>and place, a | nner as stated<br>and due to the                   | i.<br>cause(s)                         |

State Registrar

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed ase of death (Item 23a) (Type, Print)

Nes MI 32. Sglstrar's Signature

31. Date filed (Month, Day, Year) AUG 1 6 200

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** WARD /Medical 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Country) MARVLANI 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**⊠** M 2□ F Director Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydjene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo 10e. Street and Number 10g. Citizen of What Country? AVENUE Funeral Was Decedent Ever in U.S Armed Forces? Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Yes 2 🔼 No δ 3 ☐ Widowed 4 ☒ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARONDA TOWNES DAUGHTER MORE 20a. Method of Disposition 1⊠Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Do not enter the mode of dying, such as cardiac or respiratory mest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner l or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 ate has been signed by the attending physician and page 2 should be detached for use as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 2 🗆 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 100 1 Tes 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To : After this tuneral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation s after deau. ral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 a 31. Date filed (Month, Day, Registrar's Signature State

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Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Harris 1:41 P Betty Rose August 10, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hart Heritage Harford Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛣 F Yrs California Director 82 571-22-4544 1, 1924 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ehow. ed other than "naturel", or items 23a or 28a-f ehovevent, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1501 Oakville Ct. 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after at Hygiene. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: ģ 3 ☑ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Food Service Manager Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be f nent of Health and Mental I Int: if item 27 ie marked o Robert Lynn McCray Rose Ellen Barnett ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Air, MD 21014 20c. Location - City or Town, State 1501 Oakville Court, Bel position (Name of Date Kathleen E. Thomas / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 0 = 6 1 Surial 2 □ Cremation 3 MRemoval from State 4 ☐Donation 5 ☐ Other (Specify) Greenwood Memorial Pk 8-26-07 San Diego, California 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
McComas Funeral Home, P.A. emasty 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1317 Cokesbury Rd., Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Immediate Cause (Final END STASE Rementos Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sicien and burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as the attending I IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 035 Muchic 2 NO 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1□ Yes Division of Vital MSI stest the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1□Yes 2XNo Other: 4 Nursing Home 5 Residence Other (Specify) ۵ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Hospitel or Attending 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No efter death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide 24 hours e Funerei I Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the ţ, 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D35885 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MACPHAIL BULAIN, MA SPANICS BLARAD

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Hilton 165 2007 10 par /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Itimore. mol No Balti niversity of Moryland Mederal Center Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** -92-Director 18/53 Tennessee Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No GOOD Lett SVILLE Director Davidson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number nion Hill 3707 USA 1388 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) sheet metal worker Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Max Hilton ဥ Nancy\_Neal\_Moncrief 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1388 Union Hill Rd. Goodlettsville, TN. 37072 Mrs. Regina Hilton / 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🕱 Removal from State 8/10/67 4 Donation 5 Dother (Specify) White House, TN. White House Mem. Grds: 21. Signature of Funeral Service Lice 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ily one cause on each line. 23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) **Physician** 150 Demic CONDIOMYOPO /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner for use as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ Ho 24a. Was an ate has page 2 s certificate 2 4NO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Inpatient Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day . Yearl Injury 1 ■ Natural 2 □ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3∏ Suicide

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore MD Mai

0060291

State Registrar

Medical

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Charles Jansen 1- For State Certificate of Death Rea. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day August 12, 2007 0915 hrs Charles Louis Jansen **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 810 Unetta Avenue Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) g. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Country) Months Min Director 2 1 X M 213**-**62**-**1582 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f show N/A Baltimore Director 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 810 Unetta Avenue 21229 U.S.A. 23a noti with Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 12. Was Decedent Ever in U.S. items a If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death v 1 X Never Married 2 Armed Forces' Married Yes ō Specify: white If Yes, Give Year ges 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Divorced Yes 2 X No specify: "natural", 9 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) If item 27 is marked other than " her traumatic event, the Medical 21215-0036 Distribution Shields Rubber Co. 12 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Rudolph Jansen Edna Mary Lenz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 2 19a. Informant's Name/Relationship (Type, Print ) MD Carl Jansen/Brother 8226 Fort Smallwood Rd. 2nd Flr. Glen Burnie MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery. 20a. Method of Disposition Baltimore, West Arundel Crematory 8-16-2007 Burial 2 Cremation 3 Removal from State Odenton, Maryland Other Specify Donation 5 22. Name and Address of Facility Ambrose Funeral Home, ignature of Funeral Service Lice 328 Sulphur Spring Rd. Arbutus MD 21227 art I. Enter the disease, or complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Diabetic ketoacidosis /Medical Death Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Dusito (or as a rossequence of) . . . cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical X AMENDED #23a.perME. physician a UNPENDED 11/2/07\_TT g873. certificate be Box 68760. IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 3b. Was decedent pregnant in the Month Year Fetal death 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Ö þ Yes 2 No 3 Probably 4 ✔ Unknown ۵ Diabetes mellitus Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? director, page 2 1 🗸 ✓ Yes 2 No the Hospital or Attending Physician: thin 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Other4 Nursing Home 5 Residence 6 V Other: Scene DOA this Inpatient 2 ER/Outpatient 3 ٩ 1 V Yes After 28a, Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Natural Pendina Yes 2 To the Funeral Director: completely filled in by the 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mode August 12, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

**ORIGINAL** 

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month CLARA D. JONES 2007 AUG. 13 8:00A 4a. Facility Name (If not institution, give street and number) 4c. County of Death FREDERICK VILLA NURSING CENTER CATONSVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Days 92 1 □ M 2√2 F 216-36-3057 5/30/1915 CAROLINA Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits MD BALTIMORE PIKESVILLE 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7514 SHELOWOOD ROAD 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No Specify: Specify: BLACK ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) REDMOND DUNN LOUVINA BULLUCK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON RICHARD JONES, JR. 7514 SHELOWOOD ROAD, PIKESVILLE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/17/07 CHELTENHAM, MD 21. Signature of Eneral Service Licenses 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, ase, or complications that caused the death re. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death +090 Date of delivery Month Day Year contribute to the cause of death? 3 ☐ Probably 4 ☑ Unknown Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 □ No

**Physician** /Medical **Examiner** 

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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**Funeral** 

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

the Maryland

72 hours after

d 2 should be filed within; th and Mental Hygiene. 7 is marked other than "

Baltimore, Maryland 21215-0036

Examine burial-tran attending physician Physician/Medical the as ed by the a detached f signed by à Be Completed page 2 funeral director, Certification: To this To the Hospital or Attendi within 24 hours after death.

To the Funeral Director; A completely filled in by the fu

Division or Vital Records, P.O. Box 68760

| issuing in oscin,   | Due to (or as a conseq  | uence of):                    |                                     |   | ,  |
|---|---|-------------------------------|-------------------------------------|---|--|
| Sequentially list conditions, if any, leading to finine data cause. Enter Underlying    | Due to (or es a conseq  | uenne ef):                    |                                     |   |  |
| Cause (Disease or injury that initiated events resulting in death) Last                 | Due to (or as a conseq  | uence of):                    |                                     |   |  |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ❷ No 9 □ Unknown | 3c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d | I death 3 ☐ Ectopic           |                                     |   | 23d. Date of delivery<br>Month Day Yea   |
| Part II. Other significant conditions cor   | ntributing to death but not res   | ulting in the underlying      | g cause given in Part I.            | 23e. Did tobacco                            | o use contribute to the cause of deat    |
|   |   |                               |                                     | 24a. Was an — autopsy performed? 1  Yes 2 ► |  |
| 25. Was case referred to medical  |   |                               | 26. Place of £                      | Death (Check only one)                      |  |
| examiner?<br>1 ☐ Yes 2 ∰ No   | lospital: 1 ☐ Inpatient 2 ☐   | ER/Outpatient 3□              | DOA Other: 4- Nursing               | g Home 5 ☐ Residence                        | 6 □Other (Specify)                       |
| 27, Manner of Death  11 Natural 5 ☐ Pending 2 ☐ Accident investigation                  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury<br>M   | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how in                        |  |
| 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of injury - At he building, etc. (Specif                             | ome, farm, street, fact<br>y) | ory, office                         | 28f. Location (Street<br>City or Town, Sta  | and Number or Rural Route Number<br>ate) |

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30 Name and address of person who complete

6

Zibell Jef 25 31. Date filed (Month, Day, Year)

Mani Registrar's Signature

cause of death (Item 23a) (Type, Print)

D37573

29d. Date signed (Month, Day, Year) 15,2007

21136

DHMH 17 Rev 1/2001

14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Nellie Jackson /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death Jown, or Location of Death Examiner Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Year) 1 ☐ M 2 🔀 F 78 209-20-3220 Director 1928 Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1√2Yes 2□No MD Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3939 Penhurst Avenue 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 🎇 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 secretary/bookkeeper tire company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Humphrey Shoemaker Etta Eugenia Lutman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 245 Wildwood Drive #79 St. Augustine, FL 32086 Jeannie Moeller/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☑Donation 5 ☐ Other (Specify) Ronald Solve Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Party. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9 Unknown 9 Unknown been signed by should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autopsy perform 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Depatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 ⊟Natural 5 Pending investigation s after deameral Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by determined 4 THomicide within 24 hours a To the Funeral L Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Desal . Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

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32. Registrar's Signature

lB 5001

31. Date filed (Month, Day, Year)

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturary, or items 23a or 28a-f show Baltimore, Maryland 21215-0036 Physic /Med Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760,්

Fun Dire

|  |                   | For State Registrar  1. Decedent's Name (First, Middle, Last)  | ate of Maryland /  | •                     | ficate of D   |   | , ,                              | eg. No.        | ] [ ]                                  | 2.6.2.9.0<br>3. Time of Death                                |  |  |  |
|--|-------------------|--|--|-----------------------|---|---|----------------------------------|----------------|--|--|--|--|--|
| Physici  | _                 | Fode Kando   | _  |                       |   |   | Month -                          | - Day 10       | Year<br>2007                           | 09:37 AM   |  |  |  |
| /Medio<br>Examir   |                   | 4a. Facility Name (If not institution, give street  WNIVEYSIFY & MARY  |  |                       | b. City, Town, or I                                 | Location of Death                                 |                                  |                | ity of Death                           | nore   |  |  |  |
| uneral<br>irector  |                   | 5. Social Security Number  578-86-1772  Usual Residence of Decedent  | 7. Age (In yrs. last I   |                       | f Under 1 Year<br>Ionths Days                       | If Under 24 Hrs.<br>Hours Min.                    | 8. Date of Birth (Month, Day)    | , Year)        | 9. Birthpl<br>Coun                     |  |  |  |  |
| a-f show<br>lifted at  | ctor              | 10a. State 10b. County 110 N/A   | 10c. City, To  | own or Locat          | ion   |   |                                  |                | 10                                     | 0d. Inside City Limits 1 □ Yes 2 □ No                        |  |  |  |
| 23a or 28<br>st be no  | al Director       | 10e. Street and Number<br>2623 Boone Street  |  |                       | 10f. Zip Code<br>21218                              |   | 1                                | 0g. Citizen o  | f What Coun                            | try?   |  |  |  |
| Important: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral        | 1 XNever Married 2 Married 1   | /as Decedent Ever in U.S.<br>rmed Forces?<br>□Yes 2☑No<br>Yes, Give<br>ear or Dates: |                       | s Decedent of His<br>es, specify Cubar<br>Yes 20 No | spanic Origin? (Spen, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.) |                | ace - America<br>lack, White, o        | etc.   |  |  |  |
| than "natu<br>e Medical  | Completed         |  | ollege (1-4or 5+)  | (Give kin<br>life. DO | NOT use retired)                                    | urina most of worki                               | ing                              | 16b. Kind of   |  | ustry  |  |  |  |
| ked other tic event, th  | To Be Co          | 12<br>17. Father's Name ( <i>First, Middle, Last</i> )<br>Ablaye Kanda   |  | axi D                 |   | 18. Mother's Name<br>Gnima                        | E (First, Middle, i<br>Balde     |                |  |  |  |  |  |
| n 27 is mai<br>ner trauma  |                   | 19a. Informant's Name/Relationship <i>(Type. F</i><br>Hassan Fall/Executor   | 1  | 625 Fr                | rederick  | Ave., Ba  | altimore                         | , MD 2         | 21223                                  |  |  |  |  |
| tant: If iter  |                   | 20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)   |  | cipal                 | on (Name of<br>fory or other place<br>Cemetery      | 8/17  |                                  | enega          | •                                      | Africa   |  |  |  |
| Impor<br>any in  |                   | 21. Signature of Funeral Service Dicensee  | 1  | 31                    | lame and Address                                    | Sta<br>ain Rd                                     | allings<br>Pasaden               | a MD           |  |  |  |  |  |
| sician<br>edical   |                   | 23a. Part 1. Enter the 1 sease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one call on each line.  Approximate Interval Between Onset and Death disease or condition resulting in death)  a. Due to (or as a consequence of): |  |                       |   |   |                                  |                |  |  |  |  |  |
| in and<br>ial-transit  | Examiner          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Pan Creatic Cancer  Due to (or as a consequence of):  C.  Due to (or as a consequence of):   |  |                       |   |   |                                  |                |  |  |  |  |  |
| e attending physician and<br>d for use as the burial-transit   | Physician/Medical | d  | Date of delive   | ry<br>Day Year        |   |   |                                  |                |  |  |  |  |  |
| igned by the<br>be detache   | by Phys           | 9 Unknown  Part II. Other significant conditions contribu  | Unknown ting to death but not resulting  | g in the unde         | erlying cause give                                  | n in Part I.                                      |                                  |                |  | e cause of death?  |  |  |  |
| To the Funeral Director. After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use      | Completed         |  |  |                       |   |   | 24a. Was a autops perfor         | sy             | b. Were auto<br>prior to cor<br>death? | ably 4 Unknown  osy findings available  npletion of cause of |  |  |  |
| nis certifica<br>director, p   | To Be C           | 25. Was case referred to medical examiner?  1 Yes 2 Ho   | tal:<br>1 ☐ Impatient 2 ☐ ER/0   | Outpatient            | 3 DOA Othe  | 26. Place of Death                                |                                  | ne)            |  |  |  |  |  |
| ector: After the   | Certification:    | 1 ■ Natural 5 □ Pending 2 □ Accident investigation   | (Month, Day Year)  Be. Place of injury - At home,                                    | b. Time of<br>Injury  |   | ′es 2□No  |                                  | treet and Nur  |  | l Route Number,  |  |  |  |
| uneral Dir<br>ly filled in   |                   | 29a. Certifier 1 ✓ CertifyIng Physicia   | building, etc. (Specify)   | dge, death o          | ccurred at the tim                                  | e, date and place,                                | and due to the c                 | ause(s) and    | manner as st                           | ated.  |  |  |  |
| To the Fi  | Medical           |  | On the basis of examination and manner stated.                                       | anu/or inves          | 29c. License  | number  |                                  | 29d. Date sign | ned (Month,                            | Day, Year)   |  |  |  |
| 3)   |                   | 30 Name and address of person who comple   | eted cause of death (Item 23a  | a) (Type, Pri         |   | 286   | 0 2 11                           | _              | 2.0                                    | 7 2 120 1  |  |  |  |
| Sta  |                   | 31. Date filed (Month, Day, Year)  | 3 Registrar's Signature  |                       | 2+  | >11 -0  | V , 15a 1                        | INCO           | = , MI                                 | 0 2 1 2 0 1  |  |  |  |
| Regist   | ar                | AUG 1 6 2007   | Stoler A.  | 15000                 |   |   |                                  |                |  |  |  |  |  |

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Be Completed by Funeral Director

ပ္

|  | Please  | Type or Pri  |                  |                          |           |                                 |                              |                    | -  |               | egible.                |  |
|--|---|--|------------------|--------------------------|-----------|---------------------------------|------------------------------|--------------------|--|---------------|------------------------|--|
| For<br>State<br>Registrar  |   | State of M   | arylan           |                          |           |                                 | of Health<br><i>of Deatl</i> |                    |  | ene<br>g. No. | 0 6.7                  | 26299  |
|  | e (First, Middle, Las                         | st)  |                  |                          |           |                                 |                              |                    | 2. Date of Deat                          | 1             |                        | 3. Time of Death                                     |
| BLOND  | INE O. F                                      | KNIGHT   |                  |                          |           |                                 |                              |                    | Month<br>AUGUST                          | 13            | 2007                   | _ / / / / / D. A. D. A. A.                           |
| 4a. Facility Name (/   | f not institution, give                       | street and number)   |                  |                          | 4b.       | City, To                        | wn, or Location              | n of Death         |  | 4c. Co        | ounty of Dea           | ath  |
|  |   | N HOSPITK  |                  |                          |           |                                 | MORE                         |                    |  |               |                        |  |
| 5. Social Security N<br>- 219 – 26 –                               |   | ex   | e (In yrs.<br>68 | last birthda<br>Yrs      | Mo        | Under 1 Y                       | lays Hours                   | er 24 Hrs.<br>Min. | 8. Date of Birth (Month, Day, 6 / 22 / 1 |               | C                      | rthplace (State or Foreign<br>Country)<br>ARYLAND    |
| Usual Residence of   |   |  | 100 Cit          | y, Town or               | Longtio   |                                 |                              |                    |  | Long Child    |                        | 40d Incide City Limite                               |
| 10a. State<br>MD   | 10b. County N/A                               |  | Too. On          |                          |           |                                 | CITY                         |                    |  |               |                        | 10d. Inside City Limits 1 X Yes 2 ☐ No               |
|  |   |  |                  |                          |           |                                 |                              |                    | 14                                       | D. O. O.      | 6 14/1 4 0             |  |
| 10e. Street and Nu   | WINSTON                                       | AVENUE   |                  |                          | '         | Of. Zip Co                      | 21239                        |                    | "  |               | n of What C<br>USA     | ountry :   |
|  | WINDION                                       | 12. Was Decedent   | Ever in II       | 9 1                      | 2 Was     | Docadon                         |                              | Primin? (Sno       | oify Voc or No                           |               |                        | erican Indian,                                       |
| <ol> <li>Marital Status</li> <li>Dever Marr</li> </ol>             | ied 2□ Married                                | Armed Forces   | •                | .5.                      | If Yes    | s, specify                      | Cuban, Mexic                 | an, Puerto         | ecify Yes or No-<br>Rican, etc.)         | 1,4           | Black, Whi             |  |
| 3 ☐ Widowed  |   | If Yes, Give<br>Year or Dates:   |                  |                          | 1 🗆 '     | Yes 2∏X                         | No Specif                    | fy:                |  | S             | pecify: BI             | JACK   |
| (Spec  | 15. Decedent's Ed                             | lucation<br>de completed)  |                  | /G                       | ive kind  | of work o                       | Occupation                   | ost of worki       | ing                                      | 16b. Kind     | of Business            | s/Industry   |
| Elementary/Second 12   | ondary (0-12)                                 | College (1-4or   | 5+)              |                          |           | IOT use i                       |                              | ר מסד              | CEACHER                                  |               | EDIIC                  | CATION   |
| 17. Father's Name  | (First, Middle, Last)                         | <del>_</del>   |                  | _ J. L                   |           | <u></u>                         |                              |                    | (First, Middle, M                        |               |                        | VUT TON  |
| JOHN T   |   |  |                  |                          |           |                                 |                              |                    | MASON                                    |               | -,                     |  |
| 19a. Informant's N   | ame/Relationship (                            | Type. Print)   |                  | 19b. Ma                  | ailing A  | ddress (S                       | treet and Num                | ber or Rura        | al Route Number,                         | City or T     | own, State,            | Zip Code)  |
| MYRNA T  | . POWEL                                       | L / SIST   | ER               | 630                      | )1 E      | E. F                            | ORDHA                        | M DR.              | , BALT                                   | IMOH          | RE, M                  | ID 21215   |
| 20a. Method of Disp  |   |  | 20b. F           | Place of Discemetery, of | sposition | 1 (Name                         | of :                         |                    |  |               | <u> </u>               | r Town, State  |
|  | □Cremation 3 □<br>5 □ Other ( <i>Specif</i> ) | Removal from State  ()   | - 1              | DAR                      |           | -                               | i                            | 8/17               | 7/07                                     | GLEI          | N BUR                  | NIE, MD  |
| 21. Signature  | eral Service Licen                            | isee X.  | X                | en.                      |           |                                 | Address of Fac               | 110                | OWELL F                                  |               |                        | OME 21207<br>TIMORE, MD                              |
| 23a. Part / Enter t  | he discase, or comp                           | plications that cause<br>one cause on each li                          | d the deat       | h. Do not                | enter th  | e mode o                        | f dying, such a              | as cardiac o       | or respiratory arre                      | est,          |                        | Approximate<br>Interval Between                      |
| Immediat - Cause disease or condition                              | (Final  |  | SEPS             | 515                      |           |                                 |                              |                    |  |               |                        | Onset and Death                                      |
| resulting in death)  |   | a Due to (or as  | _                |                          |           |                                 |                              |                    |  |               | _                      |  |
|  |   | h  |                  | EL                       | 19        | CHE                             | MIA                          |                    |  |               |                        |  |
| Sequentially list co<br>if any, leading to in                      | nditions,<br>nmediate                         | Due to (or as  |                  |                          | 1,5       |                                 | •                            |                    |  |               |                        |  |
| Cause (Disease or<br>that initiated events                         | injury  | С.   | HYPO             | DIEN                     | 151       | 01                              |                              |                    |  |               |                        |  |
| resulting in death)  | Last  | Due to (or as  |                  |                          |           |                                 |                              |                    |  |               |                        |  |
|  |   | _d   |                  |                          |           |                                 |                              |                    |  |               |                        |  |
|  |   |  |                  |                          |           |                                 |                              |                    |  |               |                        |  |
| IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown | months?                                       | 23c. If yes, outcome<br>1 □Live birth<br>4 □ Pregnant a<br>9 □ Unknown | 2 Feta           | l death                  |           | opic pregi<br>ner <i>(speci</i> |                              |                    |  | 230           | d. Date of de<br>Month | elivery<br>Day Year                                  |
|  |   | ontributing to death b   | out not res      | ulting in th             | e underl  | ying caus                       | se given in Par              | t I.               |  |               | /                      | to the cause of death?                               |
|  |   |  |                  |                          |           |                                 |                              |                    | 1 □ Ye                                   | s 2 😿         | No 3∏F                 | Probably 4 ☐Unknown                                  |
|  |   |  |                  |                          |           |                                 |                              |                    | 24a. Was ar<br>autops<br>perform         | y<br>ned?_    | prior to<br>death?     | autopsy findings available<br>completion of cause of |
| 25. Was case refer   | red to medical                                |  |                  |                          |           |                                 | 26 Pla                       | ce of Death        | 1  Yes 2                                 | No            | 1 □ Ye                 | s 2 No   |
| examiner?<br>1 ☐ Yes 2 ☑   | _ 1   | Hospital: 1 Inpati   | ent 2□           | ER/Outpa                 | tient 3   | DOA                             | Other                        |                    |  |               | 70ther (6-             | ocify)   |
| 27. Manner of Deat   |   | 28a. Date of Inju  | ıry              | 28b. Tim                 | e of      |                                 | Injury at<br>Work?           |                    | me 5 ☐ Reside<br>28d. Describe ho        |               |                        | еспу)  |
| 1 ☑ Natural<br>2 ☐ Accident  | 5 ☐ Pending investigation                     |  | ıy Year)         | Inju                     |           | и                               | Work?<br>1 ☐ Yes 2[          |                    |  |               |                        |  |
| 3 ☐ Suicide<br>4 ☐ Homicide  | 6 Could not be determined                     | 28e. Place of in<br>building, e  | ury - At ho      | ome, farm,               | street,   | factory, o                      | ffice                        |                    | 28f. Location (St.<br>City or Town       | reet and I    | Vumber or F            | Rural Route Number,                                  |

**Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran

Physician /Medical

> Examiner Physician/Medical Medical Certification: To Be Completed by

in the pa 9 Unki Part II. Other s 25. Was case examiner? 1 ☐ Yes 27. Manner of

29a. Certifier

(Check only one)

**Physician** 

/Medical

Examiner

Funeral

Director

1 U ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number RES-000 29d. Date signed (Month, Day, Year) 8/13/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SOMNATH GHOSH 5601 LOCH RAVEN BLUD, BALTIMORE

31. Date filed (Month, Day, Year) AUG 1 6 2007



State

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| James Aurthur Ke   |               | State of Maryland / Department of H -For State Certificate of D  |   |                       | 2.00                            | 7 0:01  |  |  |  |  |  |
|--|---------------|--|---|-----------------------|---------------------------------|---|--|--|--|--|--|
| Physicia   |               | Registrar  1. Decedent's Name (First, Middle,Last)   | 200 440   | 2. Date of Deat       |                                 | 3. Time of Death                                  |  |  |  |  |  |
| Medical Examin   | -             | James A. Kelley  |   | Month<br>July 23, 20  | Day Year<br>007                 | 1850 hrs  |  |  |  |  |  |
| (  |               |  | City, Town, or Location of De                                 |                       | 4c. County of Dea               | th  |  |  |  |  |  |
|  | П             | 621 Smith Street S   | alisbury  |                       | Wicomico                        |   |  |  |  |  |  |
| Funeral  |               | - unit   | f Under 1 Year If Under 24                                    |                       |                                 | irthplace (State or Foreign<br>country) UNK       |  |  |  |  |  |
| Director   |               | 1XM 2F 52 Yrs.   | Months Days Hours I   | Min. Feb 15           | , 1955                          | curity) CITIC                                     |  |  |  |  |  |
|  | t             | Usual Residence of Decedent  | ·   |                       |                                 |   |  |  |  |  |  |
| w any  |               | 10a. State 10b. County 10c. City, Town or Location   |   |                       |                                 | 10d. Inside City Limits                           |  |  |  |  |  |
| land<br>f sho  | ō             | MD Wicomico Salisbury  |   |                       |                                 | 1 Yes 2 No  |  |  |  |  |  |
| Mary   | Director      |  | Of. Zip Code 21801  | 1                     | 0g. Citizen of What Co<br>USA   | untry?  |  |  |  |  |  |
| ith the Maryland<br>23a or 28a-f show<br>notified at once.   |               | 621 Smith Street   |   |                       |                                 |   |  |  |  |  |  |
| th wit   | eral          |  | ecedent of Hispanic Origin?<br>specify Cuban, Mexican, Pu     |                       | - 14. Race - Ame<br>White, etc. | erican Indian, Black,                             |  |  |  |  |  |
| er dea   | Fune          | 1 Yes 2 No   | a 2 V No specific   |                       | Specify: Wh                     | ita   |  |  |  |  |  |
| rs afte  | 2             | or Dates:  | s 2 X No specify:  Usual Occupation (Give kind                | of work done          |                                 |   |  |  |  |  |  |
| 2 hou<br>"nate   | ompleted      | Elementary/Secondary (0-12) College (1-4 or 5+)  | of working life. DO NOT use                                   | retired)              |                                 | arite .   |  |  |  |  |  |
| hin 7.<br>bin 7.<br>than   | ᇍ             |  |   |                       |                                 |   |  |  |  |  |  |
| 5-0036 led within 7 Hygiene. other than  | 悥             | 17. Father's Name (First, Middle, Last)  | unk 18.Mother's Na  | ame (First, Middle, I | Maiden Surname)                 | unk   |  |  |  |  |  |
| 215<br>be file<br>ntal H   | Be            |  |   |                       |                                 |   |  |  |  |  |  |
| Mer Mer  | ၉             |  | ddress (Street and Number                                     |                       |                                 | te, Zip Code)                                     |  |  |  |  |  |
| MD d 2 shoulth and m 27 is aumati  |               | 0.0011424  | nn Street Bal   |                       |                                 |   |  |  |  |  |  |
| Baltimore, ME permit Pages I and 2 s Department of Health a Important: If item 27 injury or other traum:   |               | 20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition crematory or other                      |   | Date                  | 20c. Location - City            | or Town, State                                    |  |  |  |  |  |
| Pages<br>rent o  |               | 4 Donation 5 N Other Specify: in state   |   |                       |                                 |   |  |  |  |  |  |
| Baltimore,<br>permit. Pages 1 ar<br>Department of Hee<br>Important: If ite   | Ì             | 21. Signalure of 5 1 1 al Seprice Licensee 1 ./ Director 23 Nam  | e and Addrase of Facilit Bo                                   | ard 655 W             | . Baltimor                      | e Street  |  |  |  |  |  |
| m aa iii   |               | Jenny Ball Ball  |   | 1201                  |                                 |   |  |  |  |  |  |
| Physician  |               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the n<br>failure. List only one cause on each line. | mode of dying, such as cardia                                 | ac or respiratory arr | est, shock, or heart            | Approximate Interval<br>Between Onset and         |  |  |  |  |  |
| /Medical<br>Examiner   |               | Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease   | se  |                       |                                 | Death   |  |  |  |  |  |
| Zadillillei  |               | or condition resulting in death)  Due to (or as a consequence of):   |   |                       |                                 |   |  |  |  |  |  |
|  | <u></u>       | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |   |                       |                                 |   |  |  |  |  |  |
|  | Examiner      | cause. Enter Underlying Cause  | ise. Enter Underlying Cause sease or injury that initiated C. |                       |                                 |   |  |  |  |  |  |
| P :18  | xan           | events resulting in death) Last Due to (or as a consequence of):   |   |                       |                                 |   |  |  |  |  |  |
| cecuted and transit  |               | d  |   |                       |                                 |   |  |  |  |  |  |
| be esticiar  | dical         | UNPENDED AMENDED   |   |                       |                                 |   |  |  |  |  |  |
| Division of Vital Records, P.O. Box 6876C the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physiphetely filled in by the funeral director, page 2 should be detached for use as the b | Ž             | IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy   | death 3 Ectopic pre   | ananay                | 23d. Date of deliver            | ery<br>Day Year                                   |  |  |  |  |  |
| certi  | Physician/M   | past 12 months?  | (Specify)   | griancy               | WOTH                            | Day Teal  |  |  |  |  |  |
| Box<br>e death c<br>the atten  | ysi           | 1 Yes 2 No 9 Unknown 9 Unknown   | (Specify)   |                       |                                 |   |  |  |  |  |  |
| O. O. I at the d by t  |               | Part II. Other significant conditions contributing to death but not resulting in the under   | erlying cause given in Part I.                                | 23e. Did to           | obacco use contribute           | to the cause of death?                            |  |  |  |  |  |
| cords, P.O. law requires that the has been signed by   | d by          | Chronic alcohol use  |   | 1Ye:                  | s 2 No 3 P                      | robably 4 🗹 Unknown                               |  |  |  |  |  |
| rds<br>requi   | Completed     |  |   | 24a. Was<br>autor     |                                 | autopsy findings available completion of cause of |  |  |  |  |  |
| e law<br>te has  | Ē             |  |   | perfo                 | rmed? death′<br>2 No 1 ✓        | · _   |  |  |  |  |  |
| tal Rec  |               | 25. Was case referred to medical   | 26.Place of Death (Che  |                       | 2 10 1 9                        | 103 2 100   |  |  |  |  |  |
| n of Vital Records, ding Physician: The law requir. h. After this certificate has been se fineral director, page 2 should law.   | o Be          | examiner? Hospital: 4 Inpatient 3 ER/Outpatient 3  | Other   | rsing Home 5          | Residence 6 V Oth               | ner: Scene  |  |  |  |  |  |
| of \oldsymbol{O}   |               | 27. Manner of Death 28a. Date of Injury 28b. Time of Injury  | y 28c. Injury at Work?  | 28d. Describe         | how injury occurred             |   |  |  |  |  |  |
| on arth.   | ertification: | 1 V Natural 5 Pending (Month, Day, Year)   | 1 Yes 2 No  |                       |                                 |   |  |  |  |  |  |
| Division<br>tal or Attendii<br>ins after death.  | liga          | 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, f.                                       | actory, office building, etc.                                 |                       |                                 | Rural Route Number, City                          |  |  |  |  |  |
| Divisior Spital or Attenchours after death neral Director:   | erti          | 4 Homicide determined (Specify)  |   | or Town, S            | State)                          |   |  |  |  |  |  |
| Hosp<br>24 ho<br>Fune<br>tely fi   | 3             | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred   | at the time, date and place,                                  | and due to the caus   | se(s) and manner as st          | ated.   |  |  |  |  |  |
| Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:  | Medical       | one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.   | , in my opinion, death occurr                                 | ed at the time, date  | and place, and due to           | the cause(s)                                      |  |  |  |  |  |
| F 3 F 8  | Me            | 29b. Signature and title of certifier  | 29c. License number   |                       | 29d. Date signed (A             | fonth, Day, Year)                                 |  |  |  |  |  |
|  |               | Carol Hallan   | O.C.M.E.  |                       | July 24, 2007                   |   |  |  |  |  |  |
|  |               | 30. Name and address of person who completed cause of death (Item 23a)   |   |                       |                                 |   |  |  |  |  |  |
|  |               |  | eet, Baltimore, MD 21   | 201                   |                                 |   |  |  |  |  |  |
|  | ate           | 31. Date filed (Month, Day, Year) 2007 32/ Registrar's Signature   | 2   | -                     |                                 |   |  |  |  |  |  |
| Regist   | rar           | AUG 1 6 2007 Palesteen St. September   |   |                       |                                 |   |  |  |  |  |  |

DOME

| 07-06238<br>Robert H. Kitchen  |                | Please Type or Print in Black<br>State of Maryland / De  |                        |                       |                    |   |                    |  |   |
|--|----------------|--|------------------------|-----------------------|--------------------|---|--------------------|--|---|
|  |                | •  | •                      | te of Dea             |                    | u wendi i                                 | _                  | eg. No.                                    | 3. Time of Death                                  |
| Physician<br>Medical Examine   | -              | Robert H. Kitchen  |                        |                       |                    |   | Month<br>August 12 | Day Year<br>2, 2007                        | 0124 hrs  |
| 111  |                | 4a. Facility Name (if not institution, give street and number) Southern Maryland Hospital Center                             |                        | 4b. City,<br>Clint    |                    | Location of Death                         |                    | 4c. County of Death<br>Prince George       |   |
| Funeral<br>Director  | J              | 222 38 4970 X M 2 F  | yrs. last birtho<br>54 | day) If Un<br>Mont    | ths Day            |   |                    | rth(MM/DD/YYYY) 9. Bir<br>30, 1953 Foreign | thplace (State or<br>gn<br>bunt Washing tor<br>DC |
| any in the   |                | Usual Residence of Decedent  10a. State 10b. County 10c.   | City, Town or          | r Location            |                    |   |                    |  | 10d. Inside City Limits                           |
| land<br>f show   | ٥              | Maryland Prince George's   |                        | Temp1                 |                    | 11s                                       | 100.00             | 18   | 1 Yes 2 No  |
| the Mary 3a or 28a- otified at   | Dire           | 10e. Street and Number 5001 Keppler Road   |                        | .   10f. Z            | ip Code<br>207     | 48  | , · · 1            | Og. Citizen of What Cou<br>United Stat     | •   |
| 5-0036 led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show the Maryland I was a context than "natural".  | Funeral        | 11. Marital Status  1 Never Married 2 Married Armed Forces?  1 Yes 2XX   |                        | If Yes, spec          | cify Cuba          | spanic Origin? ( Sp<br>n, Mexican, Puerto |                    | 14. Race - Amer<br>White, etc.             | rican Indian, Black,                              |
| rs after<br>ural".   | ۾              | Widowed 4 XXDivorced If Yes, Give Year or Dates.  15. Decedent's Education (Specify only highest grade complete              |                        | 1 Yes                 |                    | specify:                                  | work done          | Specify: Wh:                               |   |
| 21215-0036 rould be filed within 72 hours after d Mental Hygiene. is marked other than "natural", or   | Completed      | Elementary/Secondary (0-12) College (1-4 or 5+)  | dı                     | uring most of w       | orking life        | e. DO NOT use reti                        |                    | 7  |   |
| D 21215-0036 should be filed within 7 and Menta Hygiene. 7 is marked other than artic event, the Medica  | d lo           | 12 17. Father's Name (First, Middle, Last)   | A                      | Auto Pa               | inte:              |   | (First Middle      | Automotive Maiden Surname)                 | e Repair  |
| 215-<br>be filed<br>tral Hyg<br>ked off  | Be C           | Robert Jewel Kitchens  |                        |                       |                    | VIII                                      | e Kidd             | water surrante)                            |   |
| imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental I tant: If them 27 is marked or other traumatic event,   | ٥              | 19a. Informant's Name/Relationship (Type, Print )  | 19b.                   |                       | ,                  | et and Number or F                        | Rural Route Nu     | mber, City or Town, State                  | · · · · · ·                                       |
| aun 2  | -              | Lee Ann Kitchens (Ex Wife)  20a Method of Disposition  | 20b. Place of          | 264 B. Disposition (N | Kinra<br>ame of ce | ad Morgan                                 | Way, I             | Jothian MD 20c. Location - City o          | 20711<br>r Town, State                            |
| nore<br>ages 1<br>nt of H<br>nt: If it   |                | 1 Burial 2 XXCremation 3 Removal from State  |                        | ry or other plac      |                    | ug 18, 20                                 |                    | Clinton,                                   | MD  |
| Baltimore,<br>permit. Pages I ar<br>Department of the<br>Important: If the   |                | 4 Ponation 5 Other Specify: 21 pater of uneral ervice-ticensee   | Всс                    |                       |                    |   |                    | al Home, Inc                               |   |
|  | 4              | 23a. Part I. Enter the disease, or complications that caused the o   | death Deast            |                       |                    |   |                    | Clinton, MI                                | 20735 Approximate Interval                        |
| Physician<br>/Medical  | 7              | failure. List only one cause on each line.  Immediate Cause (Final disease a, Multiple Injuries                              | leath. Do not          | enter the mode        | e or aying         | , such as cardiac c                       | ir respiratory an  | rest, snock, or neart                      | Between Onset and<br>Death                        |
| Examiner   |                | or condition resulting in death)  Due to (or as a consequent   | nce of):               |                       |                    |   |                    |  |   |
|  | ē              | Sequentially list conditions, if any, leading to immediate Due to (or as a consequent of the conditions).                    | nce of):               |                       |                    |   |                    |  |   |
| ted (  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence) | nce of):               |                       |                    |   |                    |  |   |
| e execu  | lg<br>gi       | UNPENDED AMENDED   |                        |                       |                    |   |                    |  |   |
| Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  Ithe Funeral Director: After this certificate has been signed by the attending physician and upletely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown g Unknown                                 | 2                      | Fetal deat            |                    | Ectopic pregna                            | ancy               | 23d. Date of delive<br>Month               | ry<br>Day Year                                    |
| O. B. hat the de ed by the letached f  | by Ph          | Part II. Other significant conditions contributing to death but  | not resulting          | in the underlyi       | ng cause           | given in Part I.                          |                    | tobacco use contribute to                  |   |
| of Vital Records, P.O. in Physician: The law requires that the The this certificate has been signed by meral director, page 2 should be detach.  | Completed t    |  |                        |                       |                    |   | 24a. Was           |  | utopsy findings available completion of cause of  |
| ital Recional The lician: The last certificate last rector, page   |                | or W   |                        |                       | OC Dies            | ce of Death (Check                        | 1 🗸 Yes            | 2 No 1 🗸 Y                                 |   |
| Vital hysician this cert   | e Be           | 25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient  | 2 🗸 ER/Ou              | tpatient 3            | DOA                | Othor                                     | ng Home 5          | Residence 6 Other                          | er:   |
| Sion of Natending Ph. death. ctor: After the funeral   | $\vdash_1$     | 27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year) Aug 12, 2007                                 | 28b. T<br>0049         | ime of Injury<br>hrs  |                    | ury at Work?<br>Yes 2 ✔ No                |                    | how injury occurred<br>f motorcycle that c | ollided with a                                    |
| Division tal or Attendir urs after death. ral Director: A  | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Local 3 (Specify) Local 3                             |                        | rm, street, facto     | ory, office        | building, etc.                            | 28f. Location      |  | tural Route Number, City                          |
| Divis To the Hospital or A within 24 hours after To the Funeral Dire   | Medical C      | 29a. Certifier 1 Certifying Physician: To the best of my knowne) 2 Medical Examiner: On the basis of examina                 |                        |                       |                    |   |                    |  |   |
| To with To con   | Me             | and manner stated.  29b. Signature and title of certifier  |                        | 2                     |                    | nse number                                |                    | 29d. Date signed (M                        | -   |
|  |                | highi, mud   |                        |                       | 0.0                | .M.E.                                     |                    | August 14, 200                             | 7   |
| 7  |                | 30. Name and address of person who completed cause of death  Ling Li, MD Assistant Medical Examiner                          |                        | Street, Bal           | Itimore            | , MD 21201                                |                    |  |   |
| Sta<br>Registr   |                | 31. Date filed (Month, Day Year) AUG 1 6 2007  | ignature               | bode                  |                    |   | ****               |  |   |

ORIGINAL

|                |   |                | For<br>State<br>Registrar   | State of Maryla   |  | artment of F<br>rtificate of I                             |                                      | ,   | giene<br>Reg. No.           | 007                                       | 25302                                       |
|----------------|---|----------------|---|---|--|--|--------------------------------------|---|-----------------------------|---|---|
| No.            | Physici   |                | 1. Decedent's Name (First, Middle, La   |   | m Kure                                 | ek   |                                      | 2. Date of De<br>Month                    | Day                         | Year                                      | 3. Time of Death                            |
|                | /Medic  |                | 4a. Facility Name (If not institution, giv  | e street and number)  |  | 4b. City, Town, or   |                                      |   |                             | unty of Death                             | 8:40A                                       |
|                | 4<br>4  | ш              | Future Care Car   |   | and the state of the                   |  | more Cit                             |   |                             |   | N/A   |
| 250            | Funeral<br>Director   |                | 218-18-5999   | 6ex 7. Age (In )<br>I⊠ M 2□ F 85  | /rs. last birthday)<br>Yrs.            | If Under 1 Year Months Days                                | If Under 24 Hr<br>Hours Mir          |   | y, Year)                    | Coun                                      | lace (State or Foreign<br>try)<br>yland     |
|                | /land<br>ow   |                | Usual Residence of Decedent  10a. State 10b. County   | 10c.  | City, Town or Lo                       | ocation  |                                      |   |                             | 1   | Od. Inside City Limits                      |
|                | a-f sh<br>ified   | ctor           | Marvland N/A  |   |  | Baltimon   | ce City                              |   |                             |   | t>⊠Yes 2∐No                                 |
|                | ith the   | Director       | 10e. Street and Number  |   |  | 10f. Zip Code  |                                      |   | 10g. Citizer                | of What Coun                              | try?  |
|                | s 23a   |                | 3242 O'Donnel   |   | all 6 10 1                             | Was Dandant of L   | 21224                                | (0  |                             | ted Sta                                   |   |
| 36             | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral     | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced                               | 12. Was Decedent Ever in<br>Armed Forces?<br>1☆ Yes 2 □ No<br>If Yes, Give<br>Year or Dates: ₩₩ |  | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2🔀 No | an, Mexican, Pue<br>Specify:         | (Specify Yes of No<br>erto Rican, etc.)   |                             | Race - Americ<br>Black, White,<br>pecify: |   |
| 21215-0036     | 72 hou<br>natura<br>lical E   | Completed      | 15. Decedent's E<br>(Specify only highest gra   | ducation  | 16a. Dece                              | dent's Usual Occup   | ation                                | arking.                                   | 16b. Kind                   | of Business/Inc                           |   |
| 2              | ithin 7<br>ne.<br>nan "t  | nple           | Elementary/Secondary (0-12)   | College (1-4or 5+)  | life.                                  | kind of work done of DO NOT use retired                    | iding most of w                      | Orking                                    |                             |   |   |
| 2              | iled w<br>Hygier<br>ther th   | Col            | 11 Years   17. Father's Name (First, Middle, Last   |   | M                                      | lerchant   | 18 Mother's Na                       | ame (First, Middle                        |                             | dware S                                   | tore  |
| Maryland       | d be f<br>ental I<br>ked oi<br>c eve  | To Be          | William John K  |   |  |  |                                      | lelena Ka                                 |                             | ,   |   |
| ary            | shoul<br>and M<br>s marl  | ř              | 19a. Informant's Name/Relationship (  | Type. Print)  | 19b. Mailir                            | ng Address (Street   |                                      |   |                             |   | Code) 21 0 43                               |
|                | and 2<br>salth a<br>n 27 is   |                | Elaine K. Wienho  | lt (Daughter)   | ) 254                                  | 0 Kensing  | gton Gar                             | dens #40                                  | 5 Ell:                      | icott C                                   | ity, MD                                     |
| altimore,      | Pages 1<br>nent of He<br>ant: If iten<br>ury or oth   |                | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □   | Removal from State  | -                                      | matory or other plac                                       | · .                                  | Date                                      | 20c. Locat                  | ion - City or To                          | wn, State                                   |
| ᆵ              | t. Pag<br>rtmen<br>rtant:<br>rjury  |                | 4 ☐ Donation 5 ☐ Other (Specif  | y) S  |  | islaus Ce  |                                      | 8/15/20                                   |                             | 3altimo                                   | •   |
| Bal            | permi<br>Depar<br>Impor<br>any Ir   |                |   | ion, p.   | Ī                                      | 2. Name and Addre<br>Duda-Ruci<br>7922 Wis                 | e Ave.                               | Dundalk                                   | Mary                        |   | nc.<br>21222                                |
|                |   |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only                               | plications that caused the done cause on each line.   | eath. Do not ent                       | er the mode of dyin  | g, such as cardi                     | ac or respiratory a                       | rrest,                      |   | Approximate<br>Interval Between             |
|                | Physician   |                | Immediate Cause (Final disease or condition resulting in death)   | a. Atherosc   | Jerotic                                | HEar   | - Disea                              | se  |                             |   | Onset and Death                             |
|                | /Medical<br>Examiner  |                | Tooling in dealing  | Due to (or as a cons  | sequence of):                          |  |                                      |   |                             |   |   |
| O <sub>2</sub> | *   | jer            | Sequentially list conditions, many leading to himself to cause. Enter Underlying Cause (Disease or injury | b. Oue to (or as a corn   | sequence uty                           |  |                                      |   |                             |   |   |
|                | cuted<br>nd<br>ransit   | Examiner       | that initiated events   | C   |  |  |                                      |   |                             | · ·                                       |   |
| Š,             | cate be executed<br>physician and<br>the burial-transit   | EX             | resulting in death) Last  | Due to (or as a cons  | sequence of):                          |  |                                      |   |                             |   |   |
| 8760,          | ficate be executed<br>physician and<br>s the burlal-transit   | dical          |   | d   |  |  |                                      |   |                             |   |   |
| ×              | leath certifi<br>attending  <br>for use as  | Physician/Me   | IF FEMALE:  | 23c. If yes, outcome pf pre   | gnancy                                 |  |                                      |   | 234                         | . Date of delive                          | n/  |
| Box            | death certifi<br>e attending<br>d for use as  | iciar          | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No  | 1 □Live birth 2 □ F<br>4 □ Pregnant at time o   | etal death 3                           | ∃Ectopic pregnancy<br>∃ Other <i>(specify)</i>             |                                      |   | 230                         |   | Day Year                                    |
| J.             | ires that the de<br>signed by the a<br>be detached f  | hys            | 9 ☐ Unknown   | 9∐Unknown   |  |  |                                      |   |                             |   |   |
|                | The law requires that the ate has been signed by the bage 2 should be detached.   | þ              | Part II. Other significant conditions   | contributing to death but not   | resulting in the u                     | nderlying cause give                                       | en in Part I.                        |   |                             |   | e cause of death?                           |
| o              | w require<br>been si<br>should b  | Completed      |   |   |  |  |                                      | - 10                                      | Yes 2□N                     | √lo 3 ☐ Prob                              | ably 4 □Unknown                             |
| ည္             | has b   | mple           |   |   |  |  |                                      | 24a. Was                                  |                             | prior to cor                              | osy findings available npletion of cause of |
| Vital Records, |   |                | OF Mos case referred to medical   |   |  |  |                                      | 1□ Yes                                    | 2 No                        | death?<br>1 ☐ Yes                         | 2 No  |
|                | ysicia<br>s certi<br>directo  | To Be          | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  | Hospital: 1   Inpatient 2   | ER/Outpatien                           | nt 3 DOA Othe  |                                      | eath (Check only of<br>Home 5 ☐ Resident  |                             | Other (Specif                             |   |
| יסר            | ig Phy<br>ter thi   |                | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Year   | 28b. Time of                           |  |                                      | 28d. Describe                             |                             |   | 7   |
| 20             | endin<br>sath.<br>or: Af  | atio           | 1 Natural 5 Pending 2 Accident investigation  | 1   | / Injury                               |  | Yes 2 □ No                           |   |                             |   |   |
| DIVISION       | al or Att   | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of injury - A building, etc. (Spe  | t home, farm, str<br>ecify)            | eet, factory, office                                       |                                      | 28f. Location (S<br>City or Tox           |                             | lumber or Rura                            | l Route Number,                             |
|                | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, to  | Medical C      | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Example                                      | ysician: To the best of my<br>niner: On the basis of exam<br>and manner stated.                 | knowledge, deatl<br>nination and/or in | n occurred at the tir<br>vestigation, in my o              | ne, date and pla<br>pinion, death oc | ce, and due to the<br>curred at the time, | cause(s) an<br>date and pla | d manner as st<br>ace, and due to         | ated. the cause(s)                          |
|                | To t<br>To tl<br>comp   | Ž              | 29b. Signature and title of certifier   | )   |  | 29c. License   | 1                                    |   | Λ.                          | igned (Month, i                           |   |
|                |   |                | remand se   |   | uan                                    |  | 593/                                 |   | Augi                        | VST 13                                    | 2007  |
| 1              | 01  |                | 30. Name and address of person who Debarch I  | completed cause of death (I   | tem 23a) (Type,                        |  | N 0                                  | 5 11                                      | 100                         | 212                                       | - Q   |
|                | Sta   | te             | 31. Date filed (Month, Day, Year)   | 2. Registrar's Si   |  | Snith  | - further                            | Da Hi                                     | VIII                        | 010                                       | 07  |
|                | Registr   | -              | AUG 1 6 200   | 7 Seems S   | G034                                   | 2  |                                      |   |                             |   |   |
| DHI            | MH 17 Rev 1/20  | 001            |   | -   |  |  |                                      |   |                             |   |   |

Registrar DHMH 17 Rev 1/2001

# 07-05648

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| varue                           | ii Leveret  |                | STATE Registrar   | ; or iviaryiand /                      | •                               | nte of Deat             | th and Mental F<br>th                                     |  | g. No.                             | 7 2530   |
|---------------------------------|---|----------------|---|--|---------------------------------|-------------------------|---|--|------------------------------------|--|
| Modia                           | Physici<br>al Exami   | an/            | Decedent's Name (First, Middle,La   |  |                                 |                         |   | 2. Date of Death<br>Month<br>July 23, 20 | 1                                  | 3. Time of Death<br>0515 hrs                     |
| wiedic                          | ai Exaiiii  |                | Wardell Levere 4a. Facility Name (if not institution, g                                     |  |                                 | 4b. City,               | Town, or Location of Deat                                 |  | 4c. County of Deat                 |  |
| 9                               |   |                | Bon Secours Hospital  |  |                                 | Baltir                  |   |  |                                    |  |
|                                 | Funeral<br>Director   |                |   | Sex 7. Age                             | e (In yrs. last birth           | Yrs. If Und             | ler 1 Year If Under 24Hins Days Hours Mi                  | _  | Earn                               | rthplace (State orUNK<br>gn<br>puntry)           |
|                                 | any   | ŀ              | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town                 | or Location             |   |  |                                    | 10d. Inside City Limits                          |
|                                 | Maryland<br>28a-f show<br>d at once.  | ٥              | MD  |  | Ва                              | altimore                |   | 17.                                      |                                    | 1 X Yes 2 No                                     |
| 5                               | 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once.   | I Director     | 10e. Street and Number 3711 Clifton Ave   |  |                                 | 10f. Zip                | 21213   |  | g. Citizen of What Cor<br>USA      |  |
|                                 | death wit<br>or items 2<br>must be r  | Funeral        | 11. Marital Status 1 Never Married 2 Marrie   | Armed Forces?                          | unk                             | If Yes, speci           | ent of Hispanic Origin? ( \$<br>ify Cuban, Mexican, Puert | Specify Yes or No-<br>to Rican, etc.)    | White, etc.                        | rican Indian, Black,                             |
|                                 | rs after<br>ural",<br>miner   | à              | 3 Widowed 4 Divorce  15. Decedent's Education (Specify                                      | or Dates:                              | pleted) 16a. [                  |                         | No specify:  Occupation (Give kind of                     | work doneun k                            |                                    | lack<br>/industry unk                            |
| "                               | 72 hou<br>n "nat<br>al Exa  | Completed      | Elementary/Secondary (0-12)   | College (1-4 or 5                      |                                 | uring most of wo        | orking life. DO NOT use re                                | etired)                                  | Tob. Talle of Basilloss            | aria aria  |
| 0036                            | within 72<br>jene.<br>rer than '  | duc            |   | unk                                    |                                 |                         | - I- Constant   |  |                                    | unk  |
| 21215-0036                      | uld be filed with<br>Mental Hygiene,<br>marked other tl   | ادہ            | 17. Father's Name (First, Middle, Las   | A)                                     |                                 | u                       | nk 18.Mother's Nam  | ne (First, Middle, M                     | laiden Surname)                    | ulik .   |
| 212                             | and 2 should be fi<br>tealth and Mental<br>tem 27 is marked<br>traumatic event,   | To B           | 19a. Informant's Name/Relationship  | (Type, Print )                         | 4.1                             | -                       | S (Street and Number or                                   |  |                                    | e, Zip Code)                                     |
| Q M                             | nd 2 shoralth and 2m 27 is raumati  |                | O.C.M.E.  20a. Method of Disposition  |  |                                 | 11 Penn Disposition (Na | Street Balt   | Date Date                                | D 21201<br>20c. Location - City of | r Town State                                     |
| Baltimore.                      | permit. Pages I and 2 Department of Health Important: If item 2 injury or other traus   |                | 1 Burial 2 Cremation 3  | Removal from Sta                       |                                 | ry or other place       |   | Date                                     | 200. Location - City o             | rown, State                                      |
| ltim                            | nit. Pa<br>artmen<br>oortant<br>iry or o  | ŀ              | Donation 5 X Other Species     ignature of Funeral Service Lice                             |  | ector                           | &2. Name and            | Affaresson Facility oar                                   | A 655 W                                  | Raltimoro                          | Stroot   |
| B                               | Dep<br>Imp  |                | Ammy/1  | Leve                                   |                                 | Baltimo                 | ore, MD 212   | 01                                       |                                    | Street   |
|                                 | hysician<br>/Medical  |                | 23a. Part I. Enter the disease, or confailure. List only one cause on                       | each line.                             |                                 |                         | of dying, such as cardiac                                 | or respiratory arre                      | st, shock, or heart                | Approximate Interval Between Onset and           |
|                                 | taminer   |                | Immediate Cause (Final disease or condition resulting in death)                             | a. Compressiona  Due to (or as a conse |                                 | a                       |   |  |                                    | Death  |
|                                 |   |                | Sequentially list conditions,   | o                                      |                                 |                         |   | 2  |                                    |  |
|                                 |   | Examine        | if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated | Due to (or as a conse<br>c             |                                 |                         |   |  |                                    | 5  |
|                                 | ecuted<br>and<br>- transit  |                | events resulting in death) Last   | Due to (or as a conse                  | equence of):                    |                         |   |  |                                    |  |
| .09                             | e be ex<br>ysician<br>burial  | Medical        | X UNPENDED  | 23a,PII,27                             | ,28a-f, pe                      | erME,g870,              | 8/24/07 TT  |  | Look Bar (1977)                    |  |
| 3876                            | eath certificate be ex<br>eathending physician<br>for use as the burial   | an/M           | IF FEMALE:<br>23b. Was decedent pregnant in the<br>past 12 months?                          | 23c. If yes, outcom  1 Live birth      | 2                               |                         | 3 Ectopic pregr   | nancy                                    | 23d. Date of delive<br>Month       | ry<br>Day Year                                   |
| Box 687                         | eath ce<br>attend<br>for use  | Physician/     | 1 Yes 2 No 9 Unknow   |  | time of death 5                 | Other (Spe              | ecify)  |  |                                    |  |
|                                 | that the dense by the detached  | P.             | Part II. Other significant conditions   |  | but not resulting               | in the underlyin        | g cause given in Part I.                                  | 23e. Did tol                             | pacco use contribute t             | the cause of death?                              |
| ٦                               | ires tha<br>signed<br>I be det  | d by           | Dementia, bipol   | ar disorder; h                         | nypertensi                      | on                      |   | 1 Yes                                    | 2 No 3 Pro                         | obably 4 🗸 Unknown                               |
| ords                            | w requi   | Completed      |   |  |                                 |                         |   | 24a. Was a<br>autops                     | sy prior to                        | utopsy findings available completion of cause of |
| Reco                            | The la cate has page 2  | E O            | 1   |  |                                 |                         |   | perform<br>1 ✓ Yes 2                     |                                    |  |
| ta                              | ician: The l<br>s certificate l<br>rector, page   | Be (           | 25. Was case referred to medical examiner?  | Hospital: 1 Inpatie                    |                                 | 4-4                     | 26.Place of Death (Chec                                   |  | 2:1 6 704                          |  |
| of V                            | ling Phys<br>After this<br>funeral di   | P.             | 1 ✓ Yes 2 No<br>27. Manner of Death   | 28a. Date of Injur<br>(Month, Day,Ye   |                                 | itpatient 3 I           | DOA Other Nurs  28c. Injury at Work?                      | -  | Residence 6 Othorson One           | er:<br>  |
| ion                             | tendin<br>eath.<br>tor: A<br>the fur  | ation          | 1 Natural 5 Pending 2 X Accident Investigation  | ENd 7/10                               |                                 |                         | 1 Yes 2 X No  | subject                                  | asphyxiated                        |  |
| Division of Vital Records. P.O. | Hospital or Attend<br>24 hours after death<br>Funeral Director:<br>etely filled in by the   | Certification: | 3 Suicide 6 Could no  | 28e. Place of Inj                      | ury - At home, fa               |                         | y, office building, etc.                                  | or Town, St                              | ate)                               | ural Route Number, City                          |
|                                 | lospita<br>I hours<br>uneral<br>Iy fille  |                | 4 Homicide determine 29a. Certifier 1 Certifying Physics                                    |  | ospital                         | th conversed at th      | e time, date and place, ar                                |  |                                    | Baltimore, MD                                    |
|                                 | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Medical        |   |  |                                 |                         | y opinion, death occurred                                 |  |                                    |  |
|                                 | 5 1 × 5   | Me             | 29b. Signature and title of certifier   | and mariner stated.                    | 200                             | 29                      | lc. License number  |  | 29d. Date signed (M                | onth, Day, Year)                                 |
|                                 |   |                | totille   | nuch - f                               | bllet                           | ~ 45                    | O.C.M.E.  |  | July 24, 2007                      |  |
|                                 |   |                | <ol> <li>Name and address of person wh<br/>Patricia Aronica-Pollak N</li> </ol>             |  | eath (Item 23a)<br>Iedical Exam | iner 111 F              | enn Street, Baltimo                                       | ore, MD 21201                            |                                    |  |
|                                 |   | tate           | 31. Date filed (Month, Day, Year)   | 32. Registrar                          |                                 | 0                       |   |  |                                    |  |
|                                 | Regis   | trar           | AUG 1 6 2   | 2007 Dealers                           | J. St.                          | Coarte                  |   |  |                                    |  |

State of Maryland / Department of Health and Mental Hygiene UUT Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dav Vear Physician 1 M (:35 UDWIG INIAN 12 2007 MUGUST /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk 521 Fairview Ave. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 21 F Yrs 82 Director 220-14-2187 Feb. 5, 1925 Maryland Usual Residence of Decedent 10d Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10b. County r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Dundalk Funeral Director Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 521 Fairview Ave. United States 21224 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 24 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes X No Specify: Specify: White þ **X**☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Housewife Own Home Pages 1 and 2 should be filed w tment of Heatth and Mental Hygie tant: If item 27 is marked other t jury or other traumatic event, III. 11 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles Popp Lucy E. Wise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Grand Baltimore, Maryland 7521 Carson Ave. Fred Tarburton, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. Baltimore, Maryland 8/14/2007 <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Oak Lawn Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death art1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OYEAR **Physician** disease or condition resulting in death) DEMENTIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury Due to for as a nonsequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION CONGESTIVE HEART 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 2 No 2 No 1 Yes this certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 esidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28d. Des ribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours efter death To the Funeral Director: completely filled in by the 6 Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D62032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAYVIEW CIRCLE BALTIMORE JENN IFER SSOS ITOPKINS 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1703 PM Portia 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Mary land Medical Conter Baltware F1 Year | If Under 24 Hrs. University N/A If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2X F Director 220-68-4358 27,1958 North Carolina June Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 √Yes 2 No notified Director Maryland N/A Baltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō must be 23a 37 North Bentalow Street 21223 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian or items 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Dry Cleaning Co. 11 Years Presser 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Alice Whitley ပ Edward Earl Lee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If Item 27 is any Injury or other trau 7 Terrace Road Essex, Maryland 21221 Darvius Lee (Son) Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₭ Burial 2 Cremation 3 Removal from State 4 ☐ Donation # 5 ☐ Other (Specify) Oak Lawn Cemetery 8/15/2007 Baltimore, Maryland 21. Signatur of uneral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. Immediate Cause (Final disease or condition resulting in death) CVA **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Hortic 315566 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? pertension 2 NO 25. Was se referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this in by the funeral 28a Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide e Funeral I 1 🕒 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific AU4176435K15812 person who completed cause of death (Item 23a) (Type, Print) Greene St, Baltmar, MD 21201 hahrooz ishadi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

|          |  |  | 1 - For State Registrar   | State of                      | Marylar                                |                               | artment<br><i>tificate</i>  |                   |                     | ind Me          |                                  | ene () () 7<br>g. No.           | 26305  |
|----------|--|--|---|-------------------------------|--|-------------------------------|-----------------------------|-------------------|---------------------|-----------------|----------------------------------|---------------------------------|--|
|          | 7  |  | 1. Decedent's Name (First, Middle, Last)  |                               | ······································ | -                             |                             |                   |                     |                 | 2. Date of Death                 |                                 | 3. Time of Death   |
|          | Physici<br>/Medi   |  | Violet Vivian Lee   | 9                             |  |                               |                             |                   |                     |                 | Month<br>August                  | 7, 2007                         | 17:20 PM   |
| 1        | Examir   |  | 4a. Facility Name (If not institution, give s   | street and numb               | ber)                                   |                               | 4b. City, To                | own, or           | Location of         | f Death         |                                  | 4c. County of De                | The state of the s |
| 1        |  |  | Harford Memorial  | Hospita                       | al                                     |                               | Havr                        | e de              | e Gra               | æ               |                                  | Harfor                          | rd   |
|          | Funeral  |  | Social Security Number     6. Sex   | 7.<br>M 28C) F                |  | last birthday)                |                             | Year<br>Days      | If Under 2<br>Hours | 24 Hrs.<br>Min. | 8. Date of Birth<br>(Month, Day, | (ear) 9. Bi                     | rthplace (State or Foreign country)  |
| L.       | Director   |  | 231-24-8041   | 1141 22511                    |  | 82 Yrs.                       |                             |                   |                     |                 | May 22,                          | 1925 Vir                        |  |
|          | land   |  | Usual Residence of Decedent  10a. State 10b. County   |                               | 10c. Ci                                | ty, Town or Lo                | cation                      |                   |                     |                 |                                  |                                 | 10d. Inside City Limits  |
|          | Mary   | Ö  | Maryland Harford  |                               | E                                      | dgewood                       | 1                           |                   |                     |                 |                                  |                                 | 1 ☐ Yes 2 ☐ <b>x</b> No  |
|          | 28a  | Director   | 10e. Street and Number  |                               |  |                               | 10f. Zip C                  | ode               |                     |                 | 10                               | g. Citizen of What C            | country?   |
|          | 3a o   | 0  | 3440 Albantowne Wa  | īV                            |  |                               |                             | 1040              | 1                   |                 |                                  | USA                             |  |
|          | death<br>ms 2  | Funeral  |   | 12. Was Deced                 | ent Ever in U                          | J.S. 13. V                    |                             |                   |                     | in? (Spec       | ify Yes or No-<br>ican, etc.)    | 14. Race - Am                   | erican Indian,   |
| ٥        | or its   |  | 1 Never Married 2 Married   | Armed Force                   | No.                                    |                               |                             |                   |                     | Puerto R        | ican, etc.)                      | Black, Wh                       | ite, etc.  |
| 3        | rel',  | d by   | 3 Widowed 4 Divorced  | If Yes, Give<br>Year or Date  | es:                                    |                               | ☐ Yes 2                     | ¥ No              | Specify:            |                 |                                  | Specify:                        | hite   |
| 212-0036 | be filed within 72 hours after death with the Maryland all typiene. All the Wester then "retural", or items 23e or 28e-f ehow other then "natural" Examinar must be notified at event, the Medical Examinar must be notified at  | Completed  | 15. Decedent's Educ<br>(Specify only highest grade  | cation<br>completed)          |  | 16a. Deced                    | ent's Usual<br>kind of work | Occupat           | tion<br>uring most  | of working      | 16                               | 3b. Kind of Busines:            | s/Industry   |
| 2        | hen.   | Ig I   | Elementary/Secondary (0-12)   | College (1-4                  | lor 5+)                                | life. I                       | no notuse<br>ne mal         | retired)          |                     | o               |                                  | Own hom                         | 0  |
| Z        | ited v<br>tygie<br>her t   |  | 17. Father's Name (First, Middle, Last)   |                               |  | 110                           | 4160 1160                   |                   |                     |                 |                                  |                                 |  |
| and      | 0 = 0 5  | Be   |   | lorgon                        |  |                               |                             |                   |                     |                 | (First, Middle, Ma               | ,                               |  |
| >        | should be<br>nd Menta<br>i marked<br>imatic ev   | ပို  | Harlow Lester And   |                               |  | 401 11 11                     |                             |                   |                     |                 |                                  | Jesterman                       |  |
| 2        | d 2 s<br>th an<br>17 ls i  |  | 19a. Informant's Name/Relationship (Type<br>Deborah E. Mainwar  |                               | ahter                                  | 3440                          | g Address (S<br>Alban-      | Street ar         | nd Numbei<br>Na Mas | ror Hural<br>TG | Houte Number, (                  | City or Town, State,<br>Marylan |  |
| a)       | 1 an<br>Heal<br>em 2   |  | 20a. Method of Disposition  |                               |  | Place of Dispo                |                             |                   | ic way              | Da              |                                  | oc. Location - City o           |  |
| 2        | Pages<br>nent of<br>int: If It   |  | t ☐ urial 2 ☐ Cremation 3 ☐ Re  | emoval from St                | ate                                    | cemetery, cren                | natory or oth               | er place          | · 1                 |                 | _                                | •                               |  |
| airimoi  | 그 돈 은 글  |  | 4 ☐ Donation 5 ☐ Other (Specify)  21. Shinlature of Funeral Service License                                   |                               | Dui                                    | olin M                        |                             | _                 |                     |                 |                                  | arlington<br>neral Hom          | , Maryland   |
| Ö        | Depa<br>Impo<br>eny ii   |  | MIN. MOD.   | . L                           | 1                                      |                               |                             |                   |                     |                 |                                  | don, Mary                       |  |
|          |  |  | 23a. Part1. Enter the disease, or complic   | cations that cau              | sed the deat                           |                               |                             |                   |                     |                 | -                                |                                 | Approximate  |
|          | 2husisian  |  | 23a. Part 1. Enter the disease, or complic<br>shock, or heart failure. List only on<br>Immediate Cause (Final | e cause on ead                | th line                                | T 0                           |                             |                   | ,                   |                 | . oop. a.o.y a.r.oo              | •1                              | Interval Between<br>Onset and Death  |
|          | Physician<br>/Medical  |  | disease or condition resulting in death)  | Due to (or                    | as a conseq                            | Upper of h                    |                             |                   |                     |                 |                                  |                                 |  |
|          | Examiner   |  |   | 546 10 (61                    | as a conseq                            | derice or).                   |                             |                   |                     |                 |                                  |                                 |  |
|          |  | Jer  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying                            | Due to (or                    | as a conseq                            | uance of)-                    |                             |                   |                     |                 |                                  |                                 |  |
| 20       | cuted  | Examiner   | Cause (Disease or injury that initiated events  |                               |  |                               |                             |                   |                     |                 |                                  |                                 |  |
| ,00      | be executed<br>ician and<br>burial-transit   | Ä  | resulting in death) Last  | Due to (or                    | as a conseq                            | uence of):                    |                             |                   |                     |                 |                                  |                                 |  |
| 0        | icate be executed<br>physician and<br>s the buriat-transit   | dicai  | d   |                               |  |                               |                             |                   |                     |                 |                                  |                                 |  |
| Š        | ing p  | 0  | IF FEMALE:  |                               |  |                               |                             |                   |                     |                 |                                  | 1                               | •  |
| 5        | ath ca   | lan/   | 23b. Was decedent pregnant in the past 12 months?   |                               | n 2 🗆 Feta                             | Ideath 3□                     | Ectopic preg                | nancy             |                     |                 |                                  | 23d. Date of de                 |  |
|          | the a  | Physician/M  | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4□Pregnan<br>9□Unknow         | it at time of di                       | eath 5                        | Other (spec                 | ify)              |                     |                 |                                  | Month                           | Day Year   |
|          | hat the  |  | Part II. Other significant conditions conf  | ributing to deat              | th but not ree                         | ulting in the un              | darbina on .                |                   | in Deat I           |                 | 02a Didasha                      |                                 | o the cause of death?  |
| ,<br>ב   | signe<br>d be  | d by   | 3   | mouning to doct               |  | aiting in the un              | derlyllig cau               | se giver          | ilii Fali(i,        |                 | 1 \( \text{Yes}                  | <b>\</b>                        | robably 4 Unknown  |
| 5        | requ<br>been<br>shoul  | Completed  |   |                               |  |                               |                             |                   |                     |                 | 1 163                            | 2940 301                        |  |
| <u>.</u> | has<br>pe 2  | d l  |   |                               |  |                               |                             |                   |                     |                 | 24a. Was an autopsy              | prior to                        | utopsy findings available completion of cause of   |
| 5        | n: The ficate  |  | 05.11   |                               |  |                               |                             |                   |                     |                 | performe                         | d? death?<br>JNo 1 ☐ Yes        | 2 □ No   |
| 5        | sicial<br>certi  | o Be   | 25. Was case referred to medical examiner?  | ospital:                      |  |                               |                             | Other             |                     |                 | Check only one                   |                                 |  |
| 5 i      | r this   | H  | 1 ☐ Yes 2 € No Control No.  | 28a. Date of I                |  | ER/Outpatient<br>28b. Time of |                             |                   | 4 🗀 19urs           |                 | d. Describe how                  | De 6 ☐Other (Spe                | ecify)   |
| 5        | th.: Afte  | 흹  | 1 Natural 5 ☐ Pending<br>2 Accident investigation   | (Month,                       | Day Year)                              | Injury                        | м                           | Unjury a<br>Work? | n<br>es 2⊡N         |                 | a. December 1010                 | injury occurred                 |  |
| 2        | Atter<br>r dea<br>ector<br>by th   | 100<br>120<br>120<br>120<br>120<br>120<br>120<br>120<br>120<br>120 | 3 Suicide 6 Could not be determined   | 28e. Place of                 | Injury - At ho                         | ome, farm, stre               | et, factory, c              |                   |                     | -               | f. Location (Stree               | et and Number or R              | ural Route Number.   |
| 5 .      | s afte   | Certification:   | 4   Homicide  | building,                     | etc. (Specify                          | r)                            |                             |                   |                     |                 | City or Town,                    | State)                          |  |
|          | To the Hospital of Attending Physician: The law requires that the death certification 24 hours after docath.  Within 24 hours after docath.  To the Funcarial Directors. After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as |  | 29a. Certifier 1 Certifying Physi (Check only 2 Medical Examin  | cian: To the be               | st of my kno                           | wledge, death                 | occurred at                 | the time          | , date and          | place, an       | d due to the cau:                | se(s) and manner a              | s stated.  |
|          | in 24<br>in 24<br>the Fi   | edical   | (Check only 2 Medical Examinations)   | er: On the basi<br>and manner | s oi examinai                          | tion and/or inv               | estigation, in              | my opir           | nion, death         | occurred        | at the time, date                | and place, and du               | e to the cause(s)  |
| i        | To T   | Σ  | 29b. Signature and title of certifier   |                               |  |                               | 29c. L                      | icense r          | number              | 72-             | 29d                              | . Date signed (Mon.             |  |
|          |  |  | · wall  |                               |  |                               | 1                           | 100               | 0                   | ر کرو           |                                  | 8/8/7                           | 007  |
|          |  |  | 30. Name and address of person who con  | pleted cause of               | of death (Item                         | 23a) (Type, F                 | rint) S                     | Eo                | RGE                 | 75              | CHARM                            | 5                               |  |
|          | 6  |  | SOO MPPER   | -CIC)+                        | PEAU                                   | CINK                          | , DEC                       | AZ                | R                   | TI              | 2/01                             | 4                               |  |
|          | Star<br>Registra   |  | 31. Date filed (Month, Day, Year)   | 32. Reg                       | istrar's Signa                         | ture                          | ,                           |                   |                     |                 |                                  | •                               |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** : 45 A M 2007 and /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 7. Age (In yrs. last birthday) **Funeral** Year) Min Months 1 M 2 □ F Director Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Qa. State 10b. County 1 Ves 2 No ral", or items 23a or 28a-f sh Examiner must be notified Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 DYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 Widowed 4 Divorced 0 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mailing Address (Street and Number or Rural/Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place, City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐Removal from State Garrison Forest Vetlen 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Edneral Service Licensee 21215 HISRRIA REISTERS BAHe. md-5240-44 Approximate Interval Between Onset and Death 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 4 years irrhosis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Hepatitis B infection Examiner 10 years -hroniz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown nse 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Dav Year in the past 12 months? ned by the at e detached for 5 Other (specify) 2 No Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ signe I be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed 1□ Yes 2 ₩ No Division or Vital Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No To the Funeral Director: After this certific completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury 28h Time of 28c. Injury at Work? I or Attending F after death. Certification: (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide To the Hospital e within 24 hours at To the Funeral E Hospital 1 detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year)

Registrar

State

5

29b. Signature and title of certifie

completed cause of death (Item 23a) (Type, Print)

BUXMC 2. Registrar's Signature

D0035363

Baltmore

N. Greene St.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12 2007 12:08a McCaden Sr. Roland Reid August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Catonsville Catonsville Commons 
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Day, O2

 Months
 Days
 Hours
 Min.
 02
 28
 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 1 M 2 □ F 91 Director 219-07-9081 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 Yes 2 No Director Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. l or ns 23a must b 21229 U.S.A. 4316 Eldone Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify. 3 ☑ Widowed 4 ☐ Divorced Black Year or Dates: "natural", er than "natur the Medical I Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hutzler's Dept. Store Head Chef 8th grade 17 Is marked other traumatic event, tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Crawley 2 Benjamin McCaden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21216 Ralph McCaden-Son 1540 Moreland Ave, Baltimore, Md 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Arbutus Memorial Park 8/17/07 Arbutus, Md 21. Sign ture of Funeral Service License 22. Name and Address of Facility March F/H West 4300 Wabash Av Wabash Ave, Baltimore, md 21215 23a. Part1 Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 TYes 2 □ No 1 Yes 2 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 No Hospital: 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 1 ☐ Yes this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier frederick Ro Cetarguille, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1009, NYO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 6

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 the

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D56531 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harry Li, 8600 Snowden River PKwy, Ste 301, Columbia, mD 21045 31. Date filed (Month, Day, Year) AUG 1 6 32 Registrar's Signature 2007 **ORIGINAL** 

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 13,200708:39 **Physician** Morgan James /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 M 2 □ F MD Director 08 30 57 225-68-2236 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show t be notified at show Yes 2□No Director Baltimore MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21239 U.S.A. "natural", or items 23a idical Examiner must b 1320 Gittings Ave by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give\* Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 🏖 □ No Specify Specify: Black 3 ☐ Widowed 4 ☑ Divorced the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tailor Private <u>10th grade</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 Is marked of traumatic ever Curtis I. Morgan Herbert Harper ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health a Important: If Item 27 Is any injury or other trauonce. 21239 320 Gittings Ave, Baltimore, Md Alice Carter-Sister Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Spring Hill Bapt. 8/18/2007 Black Stone, VA Donation 5 ☐ Other (Specify) at re of Funeral Service License March F/H West 21 Si 21215 Baltimore, 4300 Wabash Ave, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ON A TO SERVICE OF THE PROPERTY O Physician /Medical ue to (or as a consequence of): Examiner 515 Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has birector, page 2 s Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 | Inpatient ER/Outpatient 3 DOA 2 Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Sea 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Natural Accident 5 ☐ Pending investigation Injury 1 Tes 2 🗌 No neral Director: / 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my oninion, death occurred at the time. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1 U basy noscon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khosrow labass Emergency

Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) AUG 1 6

6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician 2007 13 3:00 A Aug. Anna Marie Miller /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examine Timonium Baltimore Stella Maris Hospice If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Yrs 212-50-6751 Director May 26 1910 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State sa or 28a-f show t be notified at 10b. County MD Baltimore Phoenix 1 ☐ Yes X ☐ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 14621 Old York Rd. 21131 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or Items 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify Specify: white Completed by 3 Widowed 4 □ Divorced ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Own Home n/a <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic evonce. Mary Elizabeth Snitker Henry John Koerner ို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 Paper Mill Rd., Phoenix, MD 21131 Ruth L. Moore/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8/18/07 1 X Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Denation 5 □ Other (Specify) John's Lutheran Ch. Cem. Phoenix, MD Boyan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death SEVERE OSTEOARTHRITIS **Physician** MONTHS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of) Physician/Medical as attending p IF FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1☐ Yes 2፟ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been signature Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an page 2 s autopsy perform 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2X No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Director: 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

hours after Hospital 24 0

requires that the death certificate be executed

certificate

this

P.O. Box 68760,

Records,

Division or Vital

Physician:

or Attending

death.

AUGUST

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

State Registrar

29a. Certifier

29b. Signature and title of certifier

no

ERNESTINE WRIGHT, M.P. 2300 DULANEY VALLEY ROAD 31. Date filed (Month, Day, Year) AUG 1 6 2007 32. Registrar's Signature College State of

30. Na le d address of person who completed cause of death (Item 23a) Type, Print)

and manner stated.

DHMH 17 Rev 1/2001

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2007 August Irene M. Montelongo /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hospital Regional Laurel aurel If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 X X Director 466-44-5164 73 Sept 5, 1933 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1√X Yes 2 No Director TX El Paso El Paso 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 79903 USA by Funeral 4308 La Luz 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married X Yes 2□ No altimore, Maryland 21215-0036 Specify Specify: 3 Widowed 4 ☐ Divorced White Year or Dates Mexico Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) artment of Heath and Mental Hygiene ortant: If item 27 is marked other than Injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) 12 Daycare Provider Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Pages 1 and 2 should Carlos Martinez Maia Salcedo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau 79935 2317 Octubre, El Paso, TX <u>Manuel Tarango</u> Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ₩X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Bliss Nat'l Cem Aug 20, 2007 El Paso, TX 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fink Funeral Home, P.A., 426 Crain Hwy S., Glen Burnie, MD-21061 MArk Bailey M01452 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Heart **Physician** 'ears /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 KER/Outpatient 3 DOA Medical Certification: To After this 27. Manner of Death

1 Natural

2 □ Accident 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at (Month, Day 5 ☐ Pending investigation after death.

I Director: A d in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in t within 24 hours at To the Funeral C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29h. Signature and title of certifie 22766 August 15, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Rd., Emergency Dept., Laurel, MD 20707 Thomas H. Burguieres, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200 Hubert Caudill Meadows Augu /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner tealth Care System If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Director 218-26-4394 76 15, 1930 West Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 □Yes 2 NO Director Maryland Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 3705 Penny Lane Apt. D 21009 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1⊠Yes 2□No 1949 If Yes, Give Year or Dates: 1952 1 Never Married 2 Married 10 1 ☐ Yes 2 ☑ No þ Specify: 3 ☐ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Millwright 8 Steel Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hubert (nmn) Meadows Delta Clarice Cox 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other trai once. 300 Brenda Meadows / Daughter 1403 Emily Court East, Abingdon, Maryland 21009 (1) leadou Baltimore, I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 08-18-07 4 Donation 5 Dother (Specify) Air Memorial Gdn Bel Air, Maryland 21 Signature of Funeral Service Licensee 22 Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part1. Enter the discusse, or complications that caused the dea h. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear fall-re. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 8 Physician orcinone disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of The law requires that the death certificate be executed physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C Tigo Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier

State Registrar VA Maryland Health Care System Perry Point, MD. 21902

30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1631 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** August 13. 2007 00:29 A Anna Loais Mitchell /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel If Under 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 🖾 F Davs Hours 83 Director 234-42-8163
Usual Residence of Decedent July 15, 1924 Virginia 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County and Mental Hygiene. Is marked other than "natural" or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Street 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 934 Coen Road 21154 USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify 3 Widowed 4 □ Divorced Year or Dates White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Worker Shoe Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Marlan (unk) Hall or other traumatic Rosa Pearl Altizer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley J. Appel / Daughter 934 Coen Rd., Street, Maryland 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of I
Important: If It
any injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-16-07 Bel Air, Maryland Air Memorial Gdn. 2T. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 2<u>1014</u> SHI 23a. Part1. Enter the list see, or complications that caused the deal. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 5e **Physician** 2 hours /Medical Due to (or as consequence of): Examiner Ign creati Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Disease 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 7 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Dath Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ₩atural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certife auce

State Registrar

30. Name and address of pers

31. Date filed (Month, Day,

Marco

DHMH 17 Rev 1/2001

Upper Chesapeake Drive, Bel

who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

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Zamora

2007

Year)

AUG 1 6

|                |  | ı              | 1 - For<br>State<br>Registrar   | State of Maryland / Do                                  | epartment of F<br>Certificate of                 |   |                                     | ene 0 0               | 7 26315  |
|----------------|--|----------------|---|---|--|---|-------------------------------------|-----------------------|--|
|                |  |                | 1. Decedent's Name (First, Middle, Last)                                      |   |  |   | 2. Date of Death                    |                       | 3. Time of Death   |
|                | Physici  |                | Robert Sonja  | Ochorne Sr.   |  |   | August                              | 14, 200               | 6:30 P M   |
|                | /Medic<br>Examin   |                | 4a. Facility Name (If not institution, give s                                 |   | 4b. City, Town, o                                | or Location of Death                        |                                     | 4c. County of         |  |
|                | _ Admin  |                | 3536 Berkley R  | 3   | Darl   | ington                                      |                                     | Har                   | ford   |
|                | Funeral  |                | 5. Social Security Number 6. Sex  |   | day) If Under 1 Year                             | If Under 24 Hrs.                            | 8. Date of Birth                    | 9                     | . Birthplace (State or Foreign                                       |
|                | Director   |                | 218-40-8977   | M 2□F 65  | s. Months Days                                   | Hours Min.                                  | Apr. 18                             |                       | Maryland   |
|                | <u> </u>   |                | Usual Residence of Decedent   |   |  |   | 121020                              |                       |  |
|                | how  |                | 10a. State 10b. County  | 10c. City, Town   | or Location                                      |   |                                     |                       | 10d. Inside City Limits  |
|                | e Ma   | cto            | Maryland Harfo  | rdD   | arlington  |   |                                     |                       | 1 ☐ Yes 2X No  |
|                | 다 다<br>9 2 8   | Director       | 10e. Street and Number  |   | 10f. Zip Code                                    |   | 10                                  | g. Citizen of Wha     | at Country?  |
|                | 23a  | ai             | 3536 Berkley Rd.  |   | 2103   | 4   |                                     | USA                   |  |
|                | dea r  | Funerai        |   | 12. Was Decedent Ever in U.S.<br>Armed Forces?          | 13. Was Decedent of H                            | Hispanic Origin? (Sp<br>an, Mexican, Puerto | pecify Yes or No-<br>p Rican, etc.) |                       | American Indian,<br>White, etc.                                      |
| 9              | or It  |                | 1 Never Married 2 Married   | 1 ☐ Yes 2X No<br>If Yes, Give                           | 1 ☐ Yes 2 ☐ No                                   |   |                                     | Specify:              |  |
| 8              | urel',   | d by           | 3 Widowed 4 Divorced  | Year or Dates:  |  |   |                                     | 1                     | White  |
| 21215-0036     | be filed within 72 hours after death with the Maryland Hygiene. A thy by the did other then "netural", or items 23a or 28a-f ehow do other then "netural", or items 23a or 28a-f ehow event, the Medical Examinar must be notified at  | Completed      | 15. Decedent's Educ<br>(Specify only highest grade                            | completed) (  | Decedent's Usual Occup<br>Give kind of work done | during most of work                         | king 1                              | 6b. Kind of Busir     | ness/Industry  |
| 12             | hen.   | E G            | Efementary/Secondary (0-12)   | Colfege (1-4or 5+)                                      | life. DO NOT use retire                          |   |                                     | TT                    | The sale and sale  |
| C              | lied y   |                | 12 17. Father's Name (First, Middle, Last)                                    |   | Operating 1                                      |   | ne (First, Middle, M                |                       | Equipment  |
| E S            | d of be of or  | Be             |   | _   |  |   |                                     |                       |  |
| <u>=</u>       | d Me<br>d Me<br>nark   | To             | Robert Lee Osborne  19a. Informant's Name/Relationship (Ty)                   |   | Mailing Address (Street                          |   | iana Ster                           |                       | to Tip Code)   |
| Maryland       | d 2 should be filed within In and Mental Hygiene. 7 Ie marked other then "reaumatic event, the Meditalmatic events event |                |   |   |  |   |                                     | 722                   |  |
| ď,             | and Heell  |                | Robert S. Osborne 20a. Method of Disposition                                  | 1 2 4   | 3536 Berkle<br>Disposition (Name of              | ey Ra., D                                   |                                     | 0c. Location - Cit    |  |
| Baltimore,     | if it  |                | 1 Surial 2 ☐ Cremation 3 ☐ R  | emoval from State cemetery,                             | crematory or other pla                           | 1   |                                     |                       |  |
| Ë              | t. Pa<br>rtmer<br>rtent<br>sjury   | 9              | 4 Donation 5 Other (Specify)  |   | r Memorial 22. Name and Addre                    |   | 8-07 E                              | el Air,               | Maryland   |
| Bal            | permit. Pages 1<br>Department of H<br>Important: If Ite<br>ony Injury or ot<br>once.   |                | 21. 3 na ure on Funeral Ferrial Acense  |   | uneral_Ho  | me, P.A.                                    |                                     | land 21009            |  |
|                |  | -              | 23a. Part1. Enter the disease, or compli                                      | neonewy   |  |   | Approximate                         |                       |  |
|                |  |                | shock, or heart tailure. List only on   | e cause on each line.                                   |  | -   |                                     |                       | Interval Between   |
| Char           | Physician  |                | fmmediate Cause (Final disease or condition resulting in death)               | Recurrent W   | etastatio  | c sena                                      | 1 Cell Co                           | ucinou                | og 12 months   |
|                | /Medical<br>Examiner   |                | resulting in death)   | Due to (or as a consequence of                          | ):   |   |                                     |                       |  |
|                |  | L.             | Sequentially list conditions,   |   | ١.   |   |                                     |                       |  |
|                | pe is  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a consequence of                          | ):   |   |                                     |                       |  |
| ŊŖ.            | and<br>and<br>I-tran   | xan            | that initiated events cresulting in death) Last                               | . Due to (or as a consequence of                        | ).   |   |                                     |                       |  |
| %09Z8          | icate be executed<br>physicien and<br>s the burial-transit   | a<br>E         |   |   | ,  |   |                                     |                       |  |
| 87             | phys<br>the  | dicai          | d   |   |  |   |                                     |                       |  |
| 9 X            | death certific<br>a tending p<br>d for use as  | Physician/Me   | IF FEMALE:  | 3c. ff yes, outcome of pregnancy                        |  |   |                                     | 024 Pate              | f defice.  |
| Box            | aten<br>for us   | ian            | in the past 12 months?  | 1 Live birth 2 Fetal death                              | 3 ☐Ectopic pregnanc<br>5 ☐ Other (specify) _     | у   |                                     | 23d. Date of<br>Month |  |
| o              | at the de<br>by the a  | ysic           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 9☐ Unknown  | 5 Citier (specify) _                             |   |                                     |                       |  |
| P.0            | The law requires that the death certifi<br>site has been signed by the a tending s<br>bage 2 should be detached for use as   |                | Part II. Other significant conditions con                                     | tributing to death but not resulting in t               | he underlying cause giv                          | ven in Part I.                              | 23e. Did toba                       | acco use contribu     | ite to the cause of death?   |
| Vital Records, | signed<br>signed<br>d be del   | d by           | Follicular L  | imphoma   |  |   | 1 □ Yes                             | 2 1 No 31             | ☐ Probably 4 ☐Unknown  |
| Ö              | v requir   | ete            |   | 0   | <u> </u>   |   |                                     | 1                     |  |
| ec .           | has<br>has   | Completed      |   |   |  |   | 24a. Was an autopsy perform         | prio                  | re autopsy findings available<br>ir to compfetion of cause of<br>th? |
|                |  |                |   |   | -  | <u></u>                                     |                                     |                       | Yes 2□ No  |
| Zi.            | ysician: The is certificate ha   | Be             | 25. Was case referred to medical examiner?                                    | ospital:  | 0#   | 200   | th (Check only one                  |                       |  |
| ō              | Physician:<br>this certific<br>ral director,   | 7              | 1 Yes 2 No  | 1 Unpatient 2 UEH/Outp                                  | ALIENT SU DOA                                    | 4   Indising n                              | ome 5 Resider                       |                       |  |
| 2              | ling<br>After<br>Tunes   | io             | 1 ☐Naturaf 5 ☐ Pending  | 28a. Date of Injury 28b. Tir<br>(Month, Day Year) Inf   | ury Wo   | rk?<br>Yes 2∐No                             | 28d. Describe how                   | w inquiry occurred    |  |
| isi            | ttendi<br>death.<br>ctor: A<br>/ the fu  | ical           | 2 Accident investigation 3 Suicide 6 Could not be                             | 28e. Place of Injury - At home, farm                    |  | 1.63 5 1.10                                 | 28f Location (Str                   | and Number            | or Rural Route Number,   |
| Division       | or A<br>after<br>Direct<br>in by   | Certification: | 4 Homicide determined   | building, etc. (Specify)                                | ii, street, ractory, office                      |   | City or Town,                       |                       | or Adrar Modile Mulliber,  |
| _              | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer   |                | 29a. Certifier 1 Certifying Phys  | iician: To the best of my knowledge,                    | death occurred at the ti                         | me date and place                           | and due to the co-                  | sea(s) and mann       | er as stated   |
|                | 24 h   | Medical        |   | ner: On the basis of examination and and manner stated. | or investigation, in my                          | opinion, death occu                         | rred at the time, da                | te and place, and     | due to the cause(s)  |
|                | o the  | Me             | 29b. Signature and title of certifier   |   | 29c. Licens                                      | se number                                   | 29                                  | d. Date signed (/     | Month, Day, Year)  |
|                | ⊢s⊢ő   |                | ) W   | m.D.  | 5  | 45390                                       | A                                   | raust i               | 5th, 2007  |
|                |  |                | Name and address of person who co   | moleted cause of death (from 22-) (T                    | voe Print)                                       |   |                                     | 9                     |  |
|                | 8  |                |   | mpleted cause of death (ftem 23a) (T<br>GOZ The Ati     | wood Rod   | id # 201                                    | o, isel A                           | ir M                  | D21014   |
| 2 1            | Sta  | te             | 31. Date filed (Month, Day Year)  | Registrar's Signature                                   | week y   |   | ,                                   |                       | •  |
|                | Registr  |                | AUG I O ZUU   | Selection to be   | AB POR   |   |                                     |                       |  |

Robert Osborne

**Physician** 

/Medical

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

2

Completed

Be

ို

Certification:

IF FEMALE:

examiner 1 Yes

1 Natural

3 ☐ Suicide

29a. Certifier (Check only

MD

Examiner

**Funeral** 

Director

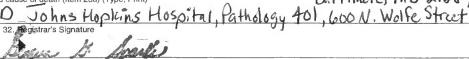
### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3: Time of Death 1. Decedent's Name (First, Middle, Last) М 3:30 P Barbara Jeanne Petersen Aug 9, 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Glen Burnie Anne Arundel 1327 Howard Rd 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 7, 1943 Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) Days Hours 1 □ M 200 F 63 219-40-9952 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Glen Burnie Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1327 Howard Rd 21060 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 1 ☐ Never Married XX Married 1 ☐ Yes X2XXX No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker County School Board 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William J. Beecher Mary Cecelia Ruehl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Louis Petersen Husband 1327 Howard Rd, Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Crownsville Vets Cem Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Aug 20, 2007 Crownsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fink Funeral Home, P.A. Mark Bailey M01452 426 Crain Hwy S., Glen Burnie, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Hyperteusire Due to (or as a consequence of): Cardiovascular disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 1 ★ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 \( \sigma \) 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 2□ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

Carla

29b. Signature and title of certifier



, MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. Ellis, mo

08/15/2007 Baltimore, mo 21287

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** VINCOUSOV /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner NORTHWEST HOSPITAL CENTER BALTIMORE RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 212-27-5314 94 UKRAINE Director 01/08/1913 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" any injury or other traumatic events. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐Yes 2√ No Funeral Director MD BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? <u>302 CANTATA COURT APT. #421</u> 21136 Race - American Indian, Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No 1 ☐ Yes 2 🂢 No Specify: WHITE þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HAIR DRESSER COSMETOLOGY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **BORIS** KERZNER UNOBTAINABLE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NONA TRUTSI / GRANDDAUGHTER <u> 109 OLD PLANTATION WAY - BALTIMORE, MD 21208</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 N Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) HAR SINAI CONG. 08/15/2007 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on jach line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tra Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 TYes 2∏No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 2 No 1 Inpatient 21 ER/Outpatient 3□ DOA 27. Mann f Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 🗌 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, After within 24 hours after death

To the Funeral Director:
completely filled in by the

State

Medical

29a, Certifiei

29b. Signature and title of certifie

1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

and manner stated.

32. Registrar's Signature 6

Registrar

# 68760, \$\frac{\display | \limin | \display | \text{Q} | \limin | \display | \text{Q} | \

|          |   |                   | Please 7  | Type or Print<br>State of Mar  |   |   |   |  | •  |   |
|----------|---|-------------------|---|--|---|---|---|--|--|---|
|          |   |                   | 1 - For State Registrar   | Otate of mai   |   | rtificate of                                    |   |  | eg. No.                                  | v oggla   |
| E'       | Physici   | an                | 1. Decedent's Name (First, Middle, Last<br>Margaret Emma Rahe   |  |   |   |   | 2. Date of Dear<br>Month<br>August         | 11, 2007 <sup>e</sup>                    | ar 3. Time of Death 10:30 p <sup>M</sup>              |
|          | /Medic  |                   | 4a. Facility Name (If not institution, give   |  |   | 4b. City, Town, o                               | r Location of Death                         |  | 4c. County of D                          |   |
|          |   |                   | 3612 Greenvale Roa  |  |   | Baltimor  |   |  | N/A                                      |   |
|          | Funeral<br>Director   |                   | 212-30-2743   |  | (In yrs. last birthday)<br>69 Yrs.          | If Under 1 Year Months Days                     | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth (Month, Day) July 13      | Year)                                    | Birthplace (State or Foreign<br>Country)<br>lary land |
|          | rland<br>ow   |                   | Usual Residence of Decedent  10a. State 10b. County   | 1  | 10c. City, Town or Lo                       | ocation   |   |  |  | 10d. Inside City Limits                               |
|          | e Mary<br>8a-f sh<br>tified   | ctor              | Md N/A  |  | Baltimore                                   | 2   |   |  |  | 1 X Yes 2 □ No  |
|          | with th   | Dire              | 10e. Street and Number  | 1  |   | 10f. Zip Code                                   |   | 1  | 0g. Citizen of What                      | Country?  |
|          | seath v   | Funeral Director  | 3612 Greenvale Roa  | 12. Was Decedent Ev  | rer in U.S. 13.                             | 21229<br>Was Decedent of F                      | Hispanic Origin? (Sp<br>an, Mexican, Puerto | pecify Yes or No-                          |  | merican Indian,                                       |
| 0000     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tier 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.                                   | by Fur            | 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced  | Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:                         | )   | If Yes, specify Cubi<br>1 ☐ Yes 2 ☑ No          | an, Mexican, Puerti<br>Specify:             | o Rican, etc.)                             | Black, V<br>Specify:                     | thite, etc.<br>White                                  |
| 3        | 2 hour<br>latural<br>ical Ex  | ted t             | 15. Decedent's Edu<br>(Specify only highest grad  | ucation  |   | dent's Usual Occup                              | oation<br>during most of work               | tina                                       | 16b. Kind of Busine                      |   |
| 7        | vithin 7<br>ne.<br>han "r<br>e Med  | Completed         | Elementary/Secondary (0-12)   | College (1-4or 5+)   | `life.                                      | DO NOT use retire                               | d)  | King                                       | D  | - t. Ct   |
| Z Z      | filed w<br>Hygie<br>other t   |                   | 17. Father's Name (First, Middle, Last)   |  | Cashi                                       | Ler   | 18. Mother's Nam                            | ne (First, Middle, I                       | Departmen<br>Maiden Surname)             | nt Store  |
| <u> </u> | uld be<br>Vental<br>Irked c   | To Be             | Roy Snyder  |  |   |   | Grace Mu                                    | ırray                                      |  |   |
|          | 2 sho<br>and h<br>is ma<br>rauma  | Ė                 | 19a. Informant's Name/Relationship (T)  | •  | I .   |   |   |  | r, City or Town, Sta                     | e, Zip Code)  |
| ב<br>ע   | 1 and<br>Health<br>em 27  |                   | Violet Herrera/Dat<br>20a. Method of Disposition  | ignter   | 20b. Place of Disponsion Cemetery, creation |   | e Road Ba                                   |  | MD ZIZZ9<br>20c. Location - City         | or Town, State  |
|          | Pages<br>sent of<br>nt: If it   |                   | 1 ☐ Burial 2 XCremation 3 ☐ I<br>4 ☐ Donation 5 ☐ Other (Specify,   |  | West Arur                                   | ndel Crem                                       | atory 8 <b>-</b> 1                          | .5 <b>-</b> 2007 (                         | denton, l                                | Maryland  |
| מפור     | permit. Departn Importa any inju  |                   | 21. Signature of Funeral Service Licens   | sed  | III S An                                    | 2, Name and Addre                               | neral Hon                                   | ne, Inc.                                   |  |   |
|          |   |                   | 23a. Par 1. Enter the disease, or for p<br>shock, or heart failure. List only o                             | lic tions that cause it  | WULLT !!                                    | 328 Sulph                                       | ur Spring                                   | r Řd. Art                                  | outus, MD                                | Approximate   |
|          | Physician   |                   | shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition                     |  | CREATI                                      |   |   |  |  | Interval Between<br>Onset and Death                   |
|          | /Medical<br>Examiner  |                   | resulting in death)   |  | consequence of):                            |   |   |  |  | 6 INJUNIA   |
|          | p #   | iner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as a   | consequence of):                            |   |   |  |  |   |
| þ.       | xecute<br>and<br>II-trans   | xaminer           | Cause (Disease or injury that initiated events resulting in death) Last                                     | c<br>Due to (or as a   | consequence of):                            |   |   |  |  |   |
| 2        | te be e.<br>ysician<br>re buria   | calE              |   | d  |   |   |   |  |  |   |
| 00       | ertifica<br>ing ph<br>e as th   | Medi              | IF FEMALE:  |  |   |   |   |  |  |   |
| .O. DO.  | To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours attend death.  To the Funeral Director: Atten this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medical | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 No<br>9 □ Unknown                         | 23c. If yes, outcome pt<br>1 □ Live birth 2<br>4 □ Pregnant at ti<br>9 □ Unknown | Fetal death 3                               | ⊒Ectopic pregnanc<br>⊒ Other <i>(specify)</i> _ | у   |  | 23d. Date of<br>Month                    | delivery<br>Day Year                                  |
| Ų,       | s that<br>gned by<br>ie deta  | by Pr             | Part II. Other significant conditions co  | ontributing to death but   | not resulting in the u                      | nderlying cause giv                             | ven in Part I.                              | 23e. Did to                                | bacco use contribut                      | e to the cause of death?                              |
| colus,   | require<br>sen sig<br>rould b   |                   |   |  |   | -   |   | 1 🗆 Y                                      | es 2 No 3                                | Probably 4 Unknown                                    |
| בים בים  | The law i<br>cate has be<br>page 2 sh   | Completed         |   |  |   |   |   | 24a. Was a autops perfor 1 Yes             | sy prior                                 |   |
| Z        | siclan:<br>certific<br>rector,  | Be                | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No   | Hospital:  | 0.0000                                      | ot 3 DOA Oth                                    | or.   | th (Check only or                          |  |   |
| 5        | g Phy:<br>er this<br>eral di  | n: To             | 27. Manner of Death   | 1 ☐ Inpatient  28a. Date of Injury (Month, Day)                                  | 28b. Time o                                 | " OLI DOA                                       | 4 Li Nursing n                              |  | ence 6 Other (a                          | Specify)  |
|          | tendin<br>eath.<br>or: Aft<br>the fur   | catio             | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be                               |  |   | M 1 🗆   | Yes 2 □ No                                  |  |  |   |
|          | tat or Att<br>s after d<br>al Direct<br>ed in by  | Certification:    | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of injury<br>building, etc.   | y - At home, farm, sti<br>(Specify)         | reet, factory, office                           |   | 28f. Location (Si<br>City or Town          | treet and Number o<br>n, State)          | r Rural Route Number,                                 |
|          | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu  | edical (          | 29a. Certifier (Check only one) Certifying Phy  | vsician: To the best of iner: On the basis of eand manner state                  | examination and/or in                       | h occurred at the ti                            | ime, date and place<br>opinion, death occu  | , and due to the d<br>irred at the time, d | ause(s) and manne<br>late and place, and | r as stated.<br>due to the cause(s)                   |
|          | To th<br>within<br>To th<br>compl   | Me                | 29b. Signature and title of certifier   | . /  | •   | 29c. Licens                                     |   | .  | 9d. Date signed (M                       |   |
|          |   |                   | > fullso  | rouley H   | 112   | DI  | 18287                                       | -  | AUG 13                                   | 2007  |

State Registrar

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DHMH 17 Rev 1/2001

07-06246

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Martin Ruffin State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Physician/ ent's Name (First, Middle,Last) 3. Time of Death Month Day August 13, 2007 Medical Examiner 1320 hrs County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death NB Rt. 29 N of Rt. 198 Burtonsville Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. **Funeral** Months Min Director 12 Country) New ( -60-8863 1XM 2 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Yes 2 No altimore with the Maryland Director 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black 11. Marital Status White, etc. Armed Forces? hours after death 1 Never Married 2 Yes Yes Give Yes 2 No specify: Divorce à 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) 72 MD 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Be (Street and Number or Rural Route Number, City or item 27 is 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 2 Donation 5 Other Specify 21. Signature of Euneral Service Licenses Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Approximate Interval Physician Between Onset and failure. List only one cause on each line /Wedle at Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause S executed? Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical UNPENDED AMENDED The law requires that the death certificate be Box 68760. 23d. Date of delivery phy: IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day past 12 months? 2 Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ģ Yes 2 ✓ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has death? performed? certificate 25. Was case referred to medical Physician: 26 Place of Death (Check only one) Division of Vital Be examiner? Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene After this 1 V Yes 28a. Date of Injury (Month, Day Year) Aug 13, 2007 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death. Certification: Pedestrian struck by van 1307 hrs 1 Natural Director: 1 ✓ Yes 2 No Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) NB Rt 29 N of Rt 198 , Burtonsville, MD To the Funeral I (Specify) Highway Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. August 14, 2007 30. Name and address of person who completed cause of death (Item 23a) 0 Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

31. Date filed Month Div. State Registra

**ORIGINAL** 

2. Registrar's Signature

4b. City. Town, or Location of Death

BALTIMORE If Under 1 Year | If Under 24 Hrs.

21207

Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

Days

BALTIMORE CITY

10f. Zip Code

1 ☐ Yes 2√☐ No

3. Time of Death

Birthplace (State or Foreign
Country)

18:48 PM

"ČAROLINA

10d. Inside City Limits

1 TYYes 2 ☐ No

Year

2007

S.

14. Bace - American Indian Black, White, etc.

Specify: BLACK

4c. County of Death

10g. Citizen of What Country?

USA

8. Date of Birth (Month, Day,

01/04/1934

Min

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LILLIE B. REGUSTERS Hugu

7. Age (In vrs. last birthday)

10c. City. Town or Location

73

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)

10b. County

5. Social Security Number

10e. Street and Number

3401

10a. State

Director

Funeral

Be

MD

216-30-5806

1 Never Married 2 Married

Usual Residence of Decedent

THE UNION MEMORIAL HOSPITAL

1 □ M 2 🔀 F

6. Sex

N/A

MILFORD AVENUE

**Funeral** Director

a or 28a-f show t be notified at Pages 1 and 2 should be filed within 72 hours after death "naturai", or than " 27 is marked or traumatic ever item 27 i other tra permit. Pages Department of Important: If it any injury or o once,

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760,

Division or Vital

**Physician** /Medical **Examiner** 

fer the discase, or complications that caused the death or heart failure. List only one cause on each line. Imme in Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed themia Due to (or as a consequence of): Physician/Medical the attending p If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> Completed To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be Hospital: 20 No ٩ 1 ☐ Yes 11 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? Certification: Injury 5 ☐ Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Medical 29a. Certifier and manner stated 29b. Signature and little of court 29c. License numbę B 30. Name and wress of person who completed cause of death (Item 23a) (Type, Print) Hessor State

þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 EDUCATOR EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BUCK HAMY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code), BALTIMORE, MD 21244 ဥ 19a. Informant's Name/Relationship (Type. Print) JOHNATHAN R. SIMMONS NEPHEW 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/20/07 WINDSOR MILL. KING MEM. PARK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of uneral Service Licenses 4600 LIBERTY HEIGHTS AVE., BALTIMORE, Do not enter the mode of dying, such as cardiac or respiratory arrest, 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy 1∏ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) AUG 1 6 Registrar's Signature

Registrar DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 6:52 AM Slabaugh William 2007 14 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore University of Maryland Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last bird If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1XM 2□F 217-50-0159 Director Nov. 4, 1949 Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Curtis Bay 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1509 Locust Street 21226 <u>United States</u> Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American In Black, White, etc. 11. Marital Status Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 2 White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) th and Mental Hygies 7 is marked other th <u>Truck Driver</u> Newspaper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Samuel Webster Slabaugh Lettie L. Adams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H. Slabaugh, Jr. Son 603 Wellesly Avenue, Baltimore, MD 21229 20b. Place of Disposition (Name of Date Method of Disposition 20c. Location - City or Town, State centerery, crematory or other place, Gardens of Faith Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 8-20-2007 Baltimore, MD Semeter And Address of Facility Ambrose Funeral Home, Inc. 21. Signature of Funeral Socie 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death on not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** epsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causs (Disease or highly that initiated events resulting in death) Last Due to (or as a consequence of): physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

be filed within 72 hours after death with the Maryland

Maryland 21215-0036

Saltimore,

funeral director, this within 24 hours after death.

To the Funeral Director: A filled in by the

the

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Aua 16646 aleek D 14 2007

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Baltimore MD

28d. Describe how injury occurred

21201

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chenell Donadee

27. Manner of Death

1 Natural

2 ☐ Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

225. Greene St. 32. Registrar's Signature

. Date of Injury (Month, Day Year)

31. Date filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

State Registrar

death certificate be executed attending physician and I for use as the burial-tran Division or Vital Records, P.O. Box 68760, been signed by the s page 2 this

Month Physician July 31, Kathleen Shah 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Gilchrst Center Towson Baltimore If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Months Hours 1 ☐ M 2 🔯 F 100-28-0129 Apr 2, 1936 Usual Residence of Decedent 10c, City, Town or Location 10a. State 10h County of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified. MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5605 Purlington Way 21212 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene.

is marked other than "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔯 No Specify. Specify: white 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nora O'Connell Patrick J. Long 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum once. 5605 Purlington Way Baltimore, MD 21212 Shirish Shah/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Romald S. Wade Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Ph.1. Enter the distance, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Mulanoma years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 / No 1 ☐ Yes 24a. Was an autopsy perform death? 1 ☐ Yes 2 □ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 Other (Specify) Certification: To funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) 1 Matural 5 ☐ Pending investigation 1 ∏Yes 2 ∏No 2 ☐ Accident after death 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours

To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Curles S+ Tonsur AMIUN MINES W 6701 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 8:05 PMM 9. Birthplace (State or Foreign Country)

New YOrk 10d. Inside City Limits 1√ Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of

**ORIGINAL** 

DHMH 17 Rev 1/2001

07-06100 Gregory Smith

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. America of Manuary Department of Health and Mental Hygiene

| regory Smith   |                | State of Maryland / Department of Health and Mental Fig. 1-For State Certificate of Death  | Reg.  | No.                                     |   |
|--|----------------|--|---|---|---|
| Physicia   | n/             | 1. Decedent's Name (First, Middle,Last) Gregory Smith  | 2. Date of Death<br>Month D<br>August 9, 20 | Day Year                                | 3. Time of Death<br>0155 hrs                        |
| al Examin  |                | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death   |   | 4c. County of Deat                      | h   |
| Funeral  | 4              | Bon Secours Hospital Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs   | . 8. Date of Birth                          | (MM/DD/YYYY) 9. Bi                      | rthplace (State or                                  |
| Director   |                | 220-64-4772 1X M 2 F 48 Yrs. Months Days Hours Min.  | Dec. 16                                     | 5, 1958 Forei                           | ountry) MD  |
|  |                | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location   |   |   | 10d. Inside City Limits                             |
| Aaryland 28a-f show  | ē              | MD   Carroll   Hampstead   10f. Zip Code   | 1100  | . Citizen of What Co                    | 1 Yes 2 X No  |
| with the Maryland is 23a or 28a-f sho  | Director       | 10e. Street and Number  1401 Topes Creek Drive  21074  |   | J.S.A.                                  | ,   |
| ≥ ≥  | — L            | 11. Marital Status 1 Never Married 2 |   | 14. Race - Ame<br>White, etc.           | rican Indian, Black,                                |
| e, MD 21215-0036 I and 2 should be filed within 72 hours after death Heath and Mental Hygiene. item 27 is marked other than "natural", or item transmatic event, the Medical Examiner must be  |                | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:   |   | Specify: Whi                            | te  |
| ours af  | od be          | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use retired.)  |   | 16b. Kind of Business                   | /Industry   |
| 36<br>nin 72 h   | Completed      | Elementary/Secondary (0-12) College (1-4 or 5+)  8 Foreman   | 1 31  | Metal War                               | ehouse  |
| 5-0036 led within 72 tygiene. other than '   | 8              | 17. Father's Name (First, Middle, Last)  18. Mother's Name   | e (First, Middle, Ma                        | eiden Surname)                          | enouse  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica   | To Be          | George LeRoy Smith Geraldin  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or  | ne Elizab<br>Rural Route Numb               | oeth Ensle<br>er, City or Town, Sta     | y<br>te, Zip Code)                                  |
| and 2 shou teath and I tem 27 is n traumatic   | ۲              | Geraldine Smith/Mother 2500 Wilkens Avenue   | Baltimor                                    | e Md 2122                               | 3   |
| TOFE, Nages I and nt of Heakl It: If item other trau   |                | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory, or other place)  20b. Place of Disposition (Name of cemetery, crematory, or other place)  20c. Place of Disposition (Name of cemetery, crematory, or other place)  8-1   |   | Brooklyn,                               |   |
| - A 9 8 8 1  | 1              | 4 Donation 5 Other Specify: 22. Name and Address of Facility Amb   |   |   |   |
| Balti<br>permit.<br>Departr<br>Import<br>injury  | V              | (1) (2719 Hammonds Ferr  | ry Rd. La                                   | ansdowne M                              | D 21227   |
|  |                | 23a. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.   | or respiratory arres                        | st, shock, or heart                     | Approximate Interval<br>Between Onset and<br>Death  |
| aminer   |                | Immediate Cause (Final disease or condition resulting in death)  a. Narcotic intoxication  Due to (or as a consequence of):  |   |   |   |
|  | <u>.</u>       | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |   |   | 1   |
| 20   | Examine        | Course Fiter III denying Course (Disease or injury that initiated  |   |   |   |
| outed &  |                | d.   |   |   |   |
| '60, 'zate be executed' physician and he burial - transit  | Medical        | IF FEMALE: 23c. If yes, outcome of pregnancy   |   | 23d. Date of delive                     | arv arv   |
| Sox 6876<br>death certificat<br>te attending phy<br>for use as the   |                | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregn  | nancy                                       | Month                                   | Day Year  |
| BOX<br>death or<br>he atten<br>d for us  | Physician/     | 1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify) 9 Unknown   |   |   |   |
| s, P.O. Bo<br>ires that the de<br>a signed by the<br>d be detached f   | by PF          | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   | to the cause of death?  robably 4  Unknown          |
| ds, Fequires   |                | <u>Cirrhosis</u>   | 24a. Was a                                  |   | autopsy findings available o completion of cause of |
| tal Records, cian: The law requir certificate has been sector, page 2 should   | Completed      |  | autops<br>perform<br>1 ✓ Yes 2              | med? death                              | ?   |
| tal R  | Be C           | 25. Was case referred to medical examiner? Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other   Nurs  |   | - · · · · · · · · · · · · · · · · · · · |   |
| of Viling Physical After this  | မ              | 1 ✓ Yes 2 No Properties 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?   |   | Residence 6 Otlow<br>Ow injury occurred | ner:<br>  |
| ion C<br>tending<br>eath.<br>tor: Af   | ation          | 1 Natural 5 Pending Investigation Fnd 8/8/2007 Fnd 2:55 pm 1 Yes 2 X No  | unk   |   |   |
| Division of Vital Rec<br>pital or Attending Physician: The I<br>ours after death.<br>Incretor: After this certificate i<br>filled in by the funeral director, page   | Certification: | 3 Suicide 6 X Could not be determined determined (specific) found: residence   | 28f. Location (S<br>2500 TWILE              | treet and Number or<br>ens Ave. Bal     | Rural Route Number, City<br>timore, MD              |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit |                | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an   | d due to the cause                          | e(s) and manner as s                    | tated.  |
| To the Hos<br>within 24 h<br>To the Fun  | Medical        | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and title of certifier 29c. License number   | at the time, date a                         | and place, and due to                   |   |
|  | 2              | 29b. Signature and the of certifier  O.C.M.E.  |   | August 9, 2007                          |   |
| Ø  |                | 30. Name and address of person who completed cause of death (Item 23a)   | 21201                                       |   |   |
| ľ  | nte            | Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 2  31. Date filed (Month, Day, Year) 32 Registrar's Signature  | 21ZUT                                       |   |   |
| ت<br>Regis   | ate            | AUG 1 6 2007 Person & Coasts   |   |   |   |

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:10a. Simmons 11 2007 /Medical Doris M August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Nursing Home Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. '. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 220-14-6581 Yrs Director 84 30 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a, State 10b. County Department of Health and Mental Hygiene. Important: If item 27a or 28a-f show Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 X Yes 2 No Funeral Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 833 West Pratt Street 21201 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Be Completed by 1 ☐ Yes 2√2 No Specify. Specify: 3 XWidowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Domestic Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Andrew Johnson Della Garner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Randell Hopkins-Nephew</u> 4402 Laplata Ave, Baltimore, Md 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【\*\*Cremation 3 ☐ Removal from State Crematory Inc 8/17/07 Baltimor
22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 4 □Donation 5 □ Other (Specify) Baltimore, Md permit. 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearh alilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute Kenal /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the page 2 should be detached 9□Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? 1□ Yes 2 1 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral D 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D0U53337 13/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dorothy Sear, wo 2835 Smith Avenue Baltmore, Md 21209 Sear 2835 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10 M Month Day Year **Physician** phine 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign
 Country) **Funeral** Days 212-58-410 1 □ M 2 □ + Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits Bultimore 1 ☐¥és 2 ☐ No Director hd 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? apt U.S. 7 21223 more Funeral . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ Specify: 13 Jack 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be avious ပ 0.1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informarit's Name/Relationship (Type. Print) Son odne. Jonese astdale 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20c. Location - City or Town, State 3 Removal from State 1-21-2007 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 1701 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Irhosi years 0 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 ☐ D0A Certification: To 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

in 24 hours area. In the Funeral Director: Affine Funeral Director: Affined in by the fu

State Registrar

npletely

within 24

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

J. CHARLES

DHMH 17 Rev 1/2001

and manner stated.

32. 🗝 gistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

6701 N Churles St Brown up

29c. License number

29d. Date signed (Month, Day, Year)

AUCUST

07-05849 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kenneth Smith 1. For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day July 31, 2007 Year 0853 hrs Medical Examiner Kenneth Smith 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Mercy Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Funeral Foreign Days Min Months Hours Director Country) 43 June 7, 1964 1 X M Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Ob. County 1 Yes 2 No MD Baltimore Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 300 E. Madison Street 21202 USA with the **23**a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. death Never Married 2 unk Yes Nο or black. Yes 2 X No specify: Widowed Divorced f Yes, Give Year Specify permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Morital Hygical Propriator. If item 27 is marked other than "natural" injury or other traumatic event, the Medical Examiner. <u>۾</u> unk 16a. Decedent's Usual Occupation (Give kind of work done 11) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retirad) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street grature Finer Serv Konald rector Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and fallure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic cardiovascular disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical tending physician as use as the burial -X UNPENDED AMENDED #23a.27.perME.g870. The law requires that the death certificate be Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? P.O. contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown Completed of Vital Records, has been si 2 should b 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 1 🗸 Yes 26 Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Be Other, examiner? Hospital: Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 this 1 Yes No 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification; 1 X Natural Division Yes 2 No d Director: ed in by the f Pending 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) August 1, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar

State

31. Date filed (Mont

Day G

| _                   |   |                   | for State Registrar   | State of Ma  | rylari                 |                      | ertificate of   |                              | ia ivie                 |                                      | giene<br>Reg. No                |  | 25327   |
|---------------------|---|-------------------|---|--|------------------------|----------------------|---|------------------------------|-------------------------|--------------------------------------|---------------------------------|--|---|
|                     | Physicia  |                   | 1. Decedent's Name (First, Middle, La<br>Jack Steele Sr.  | st)  |                        |                      |   |                              | 2                       | Date of De<br>Month<br>Aug 8,        | Da                              | •  | 3. Time of Death  |
|                     | /Medic<br>Examin  |                   | 4a. Facility Name (If not institution, giv  | e street and number)   |                        |                      | 4b. City, Town,   | or Location of I             | Death                   | Aug o,                               |                                 | . County of Deat                           |   |
|                     |   |                   | Gilchrist Hospice   |  |                        |                      | Towson  |                              |                         |                                      | 8                               | Baltimore                                  |   |
|                     | Funeral<br>Director   |                   | 5. Social Security Number 6. S<br>216.28.3594<br>Usual Residence of Decedent  | Sex 7. Age   | (In yrs. I             | ast birthday<br>Yrs. | /) If Under 1 Year<br>Months Days                               |                              | Hrs. 8<br>Min.          | Date of Bird<br>(Month, Da<br>Jan 4, | th<br>1 <i>y, Year,</i><br>1930 | ) Co                                       | hplace (State or Foreign<br>untry)<br>KY                    |
|                     | ryland<br>how<br>lat  |                   | 10a. State 10b. County  |  | 10c. City              | , Town or L          | ocation   |                              |                         |                                      |                                 |  | 10d. Inside City Limits                                     |
|                     | the Ma<br>28a-f s<br>outified   | Director          | MD Baltimore  10e. Street and Number  |  | Du                     | ındalk,              | MD<br>10f. Zip Code   |                              |                         |                                      | 10= 0                           | tinam of Milana On                         | 1 □ Yes 2 □ No  |
|                     | th with<br>23a or<br>ist be r   |                   | 607 S. Avondale Rd  |  |                        |                      | 21222   |                              |                         |                                      | Tog. Ci                         | tizen of What Co<br>USA                    | untry :   |
| Maryland 21215-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mentalle Hygiene. Them 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | d by Funeral      | 11. Marital Status  ***********************************   | 12. Was Decedent E-<br>Armed Forces?<br>1 XXYes 2 □ No<br>If Yes, Give<br>Year or Dates: |                        | S. 13.               | . Was Decedent of I<br>If Yes, specify Cub<br>1 ☐ Yes 🛣 No      |                              | n? (Specit<br>Puerto Ri | fy Yes or No<br>can, etc.)           | -                               | 14. Race - Ame<br>Black, White<br>Specify: |   |
| 7                   | "natu   | ete               | 15. Decedent's Ed<br>(Specify only highest gra  | lucation<br>ide completed)   |                        | 16a. Dece            | edent's Usual Occu<br>re kind of work done<br>DO NOT use retire | ation<br>during most o       | f working               | 11                                   | 16b. K                          | (ind of Business/                          | Industry  |
| 727                 | d within<br>giene.<br>r than<br>the Me  | Completed         | Elementary/Secondary (0-12)<br>GED  | College (1-4or 5+  | )                      | Mechai               |   | a)                           |                         |                                      | Lock                            | kheed Mart                                 | in  |
| 7                   | tal Hygi  | Be C              | 17. Father's Name (First, Middle, Last,   | ,  |                        |                      |   | 18. Mother's                 | Name (I                 | irst, Middle,                        |                                 |  |   |
| 2                   | 2 should be fi<br>and Mental H<br>is marked ot<br>aumatic ever  | မ                 | David Steele  19a. Informant's Name/Relationship (  | Time (Print)   |                        | 10h Mail             | ling Address (Street  | Pansy                        |                         | 3 t - M t                            | - 0'                            |  | 7.0.1   |
|                     | Tand 2 s Health an tem 27 is i  |                   | Jack Steele, Jr.  | Son  |                        | 1                    | 2nd Ave SW,   |                              |                         |                                      |                                 | or rown, State, 2                          | up Code)  |
| βm<br>Baltimore     | Pages 1 and of Her  |                   | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specif  | Removal from State   |                        |                      | position (Name of<br>ematory or other pla<br>ematory            |                              | Dat<br>ug 10            | e 2007                               |                                 | ocation - City or                          |   |
| Rall in             | permit. Pages<br>Department of<br>Important: If it<br>any injury or once.   |                   | 21. Signatur of Funeral Service Der   | ···  |                        | 2                    | 22. Name and Addre<br>Fink Fune<br>426 Crain                    | ess of Facility<br>rall Home | , P.A.                  |                                      | MD                              | 21061                                      |   |
|                     | Physician<br>/Medical   |                   | 23a. Part1. Enter to disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | plications that caused to one cause on each line.  a. Colora  Due to (or as a            | ctu                    | 1 0                  |   | ng, such as ca               | rdiac or r              | espiratory a                         | rrest,                          |  | Approximate Interval Between Onset and Death                |
| ,2067               | Examiner  | ner               | Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events   | bDue to (or as a   |                        |                      |   |                              |                         |                                      |                                 |  |   |
| 105+8,2<br>68760    |   | cal Examiner      | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last   | cDue to (or as a   | consequ                | ence of):            |   |                              |                         |                                      |                                 |  |   |
| Argue               | The law requires that the death certificate the has been signed by the attending physioage 2 should be detached for use as the I  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome p<br>1 □Live birth 2<br>4 □ Pregnant at ti<br>9 □ Unknown           | Fetal                  | death 3              | □Ectopic pregnanc □ Other (specify) _                           | у                            |                         |                                      |                                 | 23d. Date of del<br>Month                  | ivery<br>Day Year   |
| e rds F             | res tres tres tres tres tres tres tres t  | by                | Part II. Other significant conditions of  | ontributing to death but   | not resu               | tting in the u       | underlying cause gi   | ren in Part I.               |                         |                                      |                                 |  | the cause of death?   |
| reele               |   | Completed         |   |  |                        |                      |   |                              | _                       | 24a. Was<br>autop<br>perfo<br>1∐ Yes |                                 | I death?                                   | topsy findings available<br>completion of cause of<br>2□ No |
| Sta                 | Physiclan:<br>r this certific   | o Be              | 25. Was case referred to medical examiner? 1 ☐ Yes 🎉 No   | Hospital:  | . 2 N                  | =B/Outpatie          | ent 3 DOA Oth   | or:                          |                         | Check only o                         |                                 | a May                                      | city) MUSPICE   |
| 7 5                 | ing Phy<br>I.<br>After this<br>funeral di   | on: To            | 27. Manner of Death  1 Natural 5 Pending  | 28a. Date of Injury<br>(Month, Day   |                        | 28b. Time of         |   |                              |                         | d. Describe h                        |                                 |  | 319) 1103   109   |
| Jac /               | Attencr death ector:  | Certification:    | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined   | 1  | y - At hoi<br>(Specify | me, farm, st         | M 1   | Yes 2 □ No                   |                         | Location (S<br>City or Tox           | Street ai<br>vn, State          | nd Number or Ru<br>e)                      | ral Route Number,   |
| Ly                  | Hospital or<br>24 hours afte<br>Funeral Dir<br>tely filled in I   |                   | 29a. Certifier Certifying Ph  | ysician: To the best of  | my know                | vledge, dea          | th occurred at the ti   | me, date and                 | place, and              | d due to the                         | cause(s                         | s) and manner as                           | stated.   |
|                     | To the Ho<br>within 24 h<br>To the Fu<br>completely   | Medical           | one)  | niner: On the basis of e<br>and manner state   | examinat<br>ed.        | ion and/or i         |   |                              | occurred                |                                      |                                 |  |   |
|                     | To Vaith  | =                 | 29b. Signature and title of certifier   | )  |                        |                      | 29c. Licens   | 8303                         |                         |                                      | 29d. Da                         | ite signed (Monti                          | 1, Day, Year)   |
|                     | 3   |                   | 30. Name and address of person who  | completed cause of dea   | ath (Item              | 23a) (Type           |   | ST TA                        | 21/2c)                  | N N                                  | n                               | 21204                                      |   |
|                     | Stat<br>Registra  |                   | 31. Date filed (Month, Day, Year)   | 32. Registrar  | 6 .                    | ture                 | harles  | 10                           | , O/                    | - /                                  |                                 | /  |   |
|                     | *   |                   | nou - o   | 1  | and the                | - 19                 |   |                              |                         |                                      |                                 |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#30. per PHYS. . G870, 871, 6707, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Monthgustay a, 2007 **Physician** 04:30A M Doris Virginia Stemler /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4c. County of Death
Baltimore 4b. City, Town, or Location of Death **Examiner** Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 XF 215-32-8113 Director 89 01-05-1918 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 🔀 No Directo Maryland | Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be 400 Georgia Court. Box 235 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ₩Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within in thealth and Mental Hygiene. item 27 is marked other than "other traumatic event, the Mec Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Henry Unglaub Jennie (NMN) Gettier ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 746 S. Decker Avenue, Baltimore, MD 21224 of Disposition (Name of Date 20c. Location - City or Town, State Neil Stemler/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition . = ₽ 1 □ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Bel Air Mem. Gardens 08-11-07 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Signature of Fundal Service 22. Name and Address of Facility McComas Funeral Home, P.A., 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate sause. Enter Unidentifying Cause (Disease or injury that initiated events) set Due to (or as a consequence of): Examiner the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. physician pe Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy for Month Year Dav 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ CHRONIC OBSTRUCTIVE PULMONARY DISEASE 1 ☐ Yes 2 INo 3 ☐ Probably 4 ☐ Unknown Completed HUNTINGTON CHOREA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☑ No 24a. Was an page 2 s autopsy certificate 1∐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural 5 ☐ Pending investigation 1 Tyes 2 No 2 Accident after death 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Low D37254

State Registrar OSLER DRIVE

Towson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

BOON FOH LIM

nth, Day

7601

Registrar's Signature

07

MARYLAND 21204

# Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division or Vital Records, P.O. Box 68760, Control of the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|                   |   | Pleas                        | e Type or Prin   |                              |                             | <b>delible Ink.</b><br>artment of F   |   | •                                   |   | Legible.  |  |  |  |  |
|-------------------|---|------------------------------|--|------------------------------|-----------------------------|---|---|-------------------------------------|---|---|--|--|--|--|
|                   | for<br>State<br>Registrar   | a (First Middle              |  |                              | -                           | rtificate of  |   | -                                   | Reg. No.  | be.   | 102:12   |  |  |  |
| ian<br>cal        |   | Ramon                        | B. Sienkie   |                              | i                           |   |   | August                              | I.  |   | 3. Time of Death 5:55 P                                      |  |  |  |
| ner               | Harford   | d Memori                     | give street and number)<br>al Hospital                                 |                              |                             | Havre de  |   | h                                   | 4c.   | County of Death<br>Harford                            |  |  |  |  |
|                   | 5. Social Security N<br>212-30-88<br>Usual Residence of   | 342                          | 5. Sex 7. Ag<br>1 → M 2 → F  | 75 75                        | st birthday)<br>Yrs.        | If Under 1 Year Months Days   | If Under 24 Hrs.<br>Hours Min.                        | 8. Date of Birl<br>(Month Da        | Date of Birth (Month Day Year) 932 Sirthplace (State or Fore Mary and |   |  |  |  |  |
| tor               | 10a. State  | 10b. County Harfo            | ord  |                              | Town or Lo                  | Grace   |   |                                     |   |   | 10d. Inside City Limit                                       |  |  |  |
| al Director       | 10e. Street and Nu  | mber<br>Morrison             | Bl <b>v</b> d.   |                              |                             | 10f. Zip Code   | 1078  |                                     | 10g. Citiz  | zen of What Cou                                       | ntry?  |  |  |  |
| by Funeral        | 11. Marital Status<br>1 □ Never Marr<br>3 <b>X</b> Widowed  | ied 2☐ Marrie<br>4☐ Divorced | 12. Was Decedent Armed Forces? d 1 Yes 2 If Yes, Give Year or Dates:   |                              |                             | Was Decedent of H<br>if Yes, specify Cuba<br>1 ☐ Yes 2 ☐ No                     | lispanic Origin? (S<br>an, Mexican, Puert<br>Specify: | pecify Yes or No<br>to Rican, etc.) |   | 14. Race - Ameri<br>Black, White,<br>Specify:         |  |  |  |  |
| Completed         | (Spec   | <del></del>                  | Education<br>grade completed)  College (1-4or 5                        | 5+)                          | (Give<br>life. l            | dent's Usual Occup<br>kind of work done<br>DO NOT use retired<br><b>rmacist</b> | ation<br>during most of wor<br>d)                     | rking                               |   | nd of Business/In                                     | ndustry  |  |  |  |
| Be Co             | 17. Father's Name   | (First, Middle, La           |  |                              | FIIA                        | rillacist   | 18. Mother's Nan                                      | ne (First, Middle,                  |   |   |  |  |  |  |
| To E              | Joseph  | Sienkie                      |  | 1                            |                             |   | Wanda   | Bautro                              |   |   |  |  |  |  |
|                   | Ms. Debo  |                              | p <i>(Type. Print)</i><br>Ighty/ Daugh                                 | nter                         |                             | ng Address <i>(Street</i><br>Morrisor   |   |                                     |   |   | *  |  |  |  |
|                   |   | ☐Cremation 3                 |  | cer                          | netery, crer                | sition (Name of<br>matory or other place  | · :   | Date                                |   | cation - City or To                                   |  |  |  |  |
|                   | 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Eacily Uneral Home, 1050 York Rd. Towson, Md.                                      |                              |  |                              |                             |   |   |                                     |   | Woodlawn, Md.   |  |  |  |  |
|                   | <b>-</b>  | M                            | 1 4  |                              |                             | 1050 Yor  | Rd. To  | wson, Mo                            | ā: 2  | 1204  |  |  |  |  |
| ical Examiner     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence 1)  Due to (or as a consequence of): |                              |  |                              |                             |   |   |                                     |   |   | oyear  |  |  |  |
| Physician/Medical | IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 □ 9 □ Unknown  | months?<br>☐ No              | 23c. If yes, outcome<br>1 □Live birth<br>4 □Pregnant at<br>9 □ Unknown | 2 Fetal d                    | eath 3                      | Ectopic pregnancy   | ,   |                                     | 2   | 3d. Date of deliv                                     | ery<br>Day Year  |  |  |  |
| þ                 | Part II. Other signit   | icant condition              | s contributing to death b  | ut not result                | ing in the ur               | nderlying cause giv   | en in Part I.   |                                     | obacco us<br>/es 2[   | /   | ause of death?<br>bably 4 □Unknov                            |  |  |  |
| Completed         |   | teo                          | erthriti   | S                            |                             |   |   | 24a. Was<br>autop<br>perfo<br>1 Yes |   | 24b. Were auto<br>prior to co<br>death?<br>1 ☐ Yes    | opsy findings availab<br>impletion of cause of<br>2 \( \) No |  |  |  |
| Be                | 25. Was case referexaminer?   |                              | Hospital:  |                              |                             | Oth   |   | ath (Check only o                   |   |   |  |  |  |  |
| ation: To         | 1 Yes 2 No  |                              |  |                              |                             |   |   |                                     |   |   | fy)  |  |  |  |
| Certification:    | 3□ Suicide<br>4□Homicide  | 6 Could no determin          | ad   26e. Place of inju  | ury - At hom<br>c. (Specify) | e, farm, str                | eet, factory, office  |   | 28f. Location (S<br>City or Tow     | Street and<br>vn, State)  | d Number or Run                                       | al Route Number,   |  |  |  |
| Medical           | 29a. Certifier (Check only one)  29b. Signature and   | 1 Certifying 2 Medical Ex    | Physician: To the best<br>xaminer: On the basis o<br>and manner sta    | f examinatio                 | edge, death<br>in and/or in | n occurred at the tir<br>vestigation, in my c                                   | pinion, death occu                                    | urred at the time,                  | date and  | and manner as s<br>place, and due t<br>signed (Month, | to the cause(s)  |  |  |  |
|                   | 1   | ess of person wi             | ho completed cause of d  | eath (Item 2                 | ßa)(Twoe                    | D34   | 124   |                                     | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \                                 | 110/0   | 7  |  |  |  |
| 4                 | JOHND-  | MITO                         | MD 760   | 00 051                       | er Di                       | 7270  | TOWSUN  | n, Md                               |   | 21201   | <i>L</i>   |  |  |  |
| ate<br>rar        | 31. Date filed (Mon   | th, Day, Year)               | 32. Registr  | ar's Signatu                 | Goza                        | ( )   |   |                                     |   | ,   |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 7.8 per fil 9870 8-24-07 vt.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Taylor a 11:56 2007 Debarah /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 💢 F Hours 59 Director 214-44-1071 MD Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Baltimore NA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 U.S.A. 812 Wedgewood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after (Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ð 3 ☐ Widowed ¾ ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Proctor & Gamble Co permit. Pages 1 and 2 should be filled wire Department of Health and Mental Hygien Important: If then 27 Is marked other the any Injury or other traumatic event, the once. Supervisor 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nona Arlene Reeves Alonzo White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1719 Presstman Street, Baltimore, Md 21217 Anita Taylor-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X□ Burial 2 □ Cremation 3 □ Removal from State Baltimore Co, Md 8/20/07 4 □ Donation 5 □ Other (Specify) Woodlawn 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Signature of Funeral Service Licensee 21215 Baltimore, Md 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOLUCER THY 6 months /Medical Due to (or as a consequence of) Examiner 10 minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CARNIAC ARREST Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: signed by the attending to be detached for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify). 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2☐NO 3☐ Probably 4☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 1 Impatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending P Certification: 1 Natural Injury 5 Pending within 24 hours after upcom.

To the Funeral Director: After the Funeral Director of the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier C-A053951 00109107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

MAURICE

31. Date filed (Month, Day, Year)

AUG 1 6 2007

marke

3 Registrar's Signature

s. wolle Street

Baltimero MD

Thomas

1. Decedent's Name (First, Middle, Last)

Mary

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Elizabeth

Reg. No. 2. Date of Death

14

2007

Month

August

3. Time of Death

11:00a M

MD

10d. Inside City Limits

1 X Yes 2 □ No

9. Birthplace (State or Foreign

Black

21215

Approximate Interval Between Onset and Death

2 hours

Year

Day

3 ☐ Probably 4 ☐ Unknown

| Physician         |
|-------------------|
| /Medical          |
| Examiner          |
| roll mornioration |

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 313 West 31st Street Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 □ F Months Yrs. Director 96 07 31 215-32-7943 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10b County 10c. City, Town or Location Director MD NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 West 31st Street 21211 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ Specify: **X**☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Domestic Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Martha Robinson ဂ္ Jeremiah Buchan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy T. Nash-Daughter 313 West 31st Street, Baltimore, Md 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Memorial Park 8/20/07 Randallstown, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore, Md 21 Signature of Funeral Service Licensee 23a. Par 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause of each line. Immeriate Cause (Final diseate or condition resiting in death) **Physician** Probable Myocardia /Medical Due to (or as a consequence of): Examiner Hyperten Sim Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Ity perlipidemia physiclan and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy Month 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ montal Meninai oma 2 No 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has birector, page 2 s 24a. Was an autopsy performe 1□ Yes 2□ the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 4 Nursing Home ို 1 🔲 Yes 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D4S515 MD Raymy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3333N. Calvert St. Suite 655 Baltimore MD 21218 EAMY

32 Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 1 6 2007

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:50P M ROBERT LEE TOWNES, JR. AUG. 10, 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 4809 LANIER AVENUE BALTIMORE CITY Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 51 Yrs. 219-62-3370 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 Yes 2 No N/ABALTIMORE CITY **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4809 LANIER AVENUE 21215 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) INSTITUTE FOR College (1-4or 5+) Elementary/Secondary (0-12) BEHAVIOR RESOUCES FACILITY ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be find and Mental h Be ROBERT LEE TOWNES, SR. GLADYS BAZEMORE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jen.

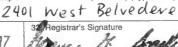
Jermit. Pages 1 and 2.
Department of Health an.
Important: If item 27 any injury or conce. LEESA TOWNES / WIFE 4809 LANIER AVENUE, BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PK | 8/17/07 WINDSOR MILL, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 eral Service Licensee 4600 LIBERTY HEIGHTS AVE., BALTIMORE, ise, or complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest, b. List only one cause on each line. Onset and Death se (Final colon **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner be executed nding physician and use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1□ Yes 2 No page 2 death? 1 ☐ Yes 2X No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident withIn 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 20057256 2007

Registrar

31. Date filed (Month, Day, Year) AUG 1 6 2007

Pallari Kumar



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue, Baltimore, Maryland 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** C. TOUCHARD, SR. WALTER 6:46A 10. 2007 AUGUST /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE TOWSON GILCHRIST HOSPICE CENTER If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth 10-31-1930 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 76 Yrs. 5. Social Security Number 6. Sex **Funeral** Months Hours MARYLAND 213-28-2998 1 M 2 □ F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at ROSEDALE 1 ☐ Yes Ž☐ No BALTIMORE MD Director 10g. Citizen of What Country? 10e Street and Number U.S.A. 21237 9919 PHILADELPHIA ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. XYes 2 No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates 952-60 1 ☐ Yes 2 No Specify: WHITE Specify. Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BETHLEHAM STEEL SUPERINTENDENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) (MEAGHER) **EMMA** E. TOUCHARD WILLIAM ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21237 9919 PHILADELPHIA ROAD ROSEDALE, MICHAEL TOUCHARD/SON other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 0 1 Burial 2 □ Cremation 3 □ Removal from State Department or Important: If any Injury or LOUDON PARK CEM. 8-14-2007 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Fur ev I Service Licensee 21237 ROSEDALE, MD 1211 CHESACO AVE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the cause Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 ☐ Probably 4 ☐ Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Wospice Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA ဥ ij this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles ST MD

Registrar

State

2. Registrar's Signature

Year)

6

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician LOUISE 0750 ANNA TELLJOHANN AUGUST 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** n/a UNION MEMORIAL HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months MARCH 4, 1926 219 22 7096 1 □ M 2√2√5 81 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2XNo ROSEDALE MD BALTIMORE Director 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 1208 KRUEGER AVENUE 21237 USA Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🍎 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married WHITE 1 ☐ Yes 2 No Specify Specify: If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KLEIN JOHN SCHAFER HELEN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1208 KRUEGER AVENUE BALTIMORE, MD 21237 MELVIN A. TELLJOHANN Jr/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3 ☐Removal from State 1 ☐ Burial 2 ☐ Cremation 4 □ Donation 5 Nother (Specify) FNICMENT GARDENS OF FAITH 8/18/07 BALTIMORE, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardia Due to (or as a conseduence of): chemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Nnpatient Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) Injury 5 ☐ Pending investigation 1 Natural 2 Accident

**Physician** /Medical Examiner and

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Box 68760,

P.0

Division or Vital Records,

Physician:

"natural", or items 23a or 28a-f show edical Examiner must be notified at

the Medical

other

Department of Health and Mental Important: if item 27 is marked of any injury or other traumatic even

1 and 2 should be Health and Mental

Pages 1

burial-trar attending physician as the l nse for the detached þ certificate has

this

funeral director, To the Hospital of within 24 hours at To the Funeral D

e Hospital or Attending P 24 hours after death. e Funeral Director: After t

State Registrar 1 □ Yes 2 □ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

ed cause of death (Item 23a) (Type, Print)

6 ☐ Could not be

determined

3 ☐ Suicide

4 ☐ Homicide

32. Registrar's Signature

|  |   | For<br>State<br>Registrar  | State of Maryland  |   | artment of H<br>rtificate of L   |  |  | Reg. No.   | 2 1 2  | 2535   |
|--|---|--|--|---|--|--|--|--|--|--|
|  |   | Negistrar     Name (First, Middle, Last)  1. Decedent's Name (First, Middle, Last)   | st)  |   |  |  | 2. Date of Dea   | ath  | Voor   | 3. Time of Death   |
| Physic<br>/Medi  |   | Bun Soon Shi   | in   |   |  |  | August   | 14 <sup>, 20</sup>   | 07 Year  | 9:30 P   |
| Exami  |   | 4a. Facility Name (If not institution, give  | street and number)   |   | 4b. City, Town, or   | Location of Death  | 1  |  | nty of Deatl   |  |
|  | 20  | Stella Maris   |  | - A foliable days   | Timoni<br>If Under 1 Year  | LIM<br>If Under 24 Hrs.  | 8. Date of Birt  |  | Baltin   | NOTE hplace (State or Fore   |
| Funeral<br>Director  | П   | 5. Social Security Number 6. S 219–98–6009   | ex 7. Age (In yrs. Ia  | Yrs.  | Months Days  | Hours Min.   | (Month Da  | v Year)  | Cou  | uth Korea  |
| 2 >  |   | Usual Residence of Decedent  10a. State 10b. County  | 10c. City.   | Town or Lo  | ocation  |  |  |  | -  | 10d. Inside City Lim   |
| should be filed within 72 hours after beath with the marytain. Id Mental Hygiene. marked other than "natural", or items 23a or 28a-f show mattee event, the Medical Examiner must be notified at   | ō   | MD Baltimo   |  | 1timo:  |  |  |  |  |  | 1 □Yes 2√√   |
| 28a-<br>notifi   | Director  | 10e. Street and Number   | 310 50   | 1 0111101   | 10f. Zip Code  |  |  | 10g. Citizen   | of What Co   | untry?   |
| 3a or  | io le   | 3 Bartley Court  |  |   | 21236  |  |  | Π  | SA .   |  |
| ms 2   | Funeral   | 11. Marital Status   | 12. Was Decedent Ever in U.S<br>Armed Forces?  | 3. 13.  | Was Decedent of H<br>If Yes, specify Cuba  | ispanic Origin? (S<br>an, Mexican, Puer  | pecify Yes or No<br>to Rican, etc.)  | . 14.  | Race - Ame   | rican Indian,<br>e, etc.   |
| or Ite   |   | 1 Never Married 2 Married  | Armed Forces? 1 ☐ Yes <b>2</b> 2 No If Yes, Give   |   | 1 ☐ Yes 2 🛣 No   | Specify:   |  |  | ecify:   | Korean   |
| ural",   | d by  | 3XWidowed 4 □ Divorced   | Year or Dates:   | 16a Dece  | dent's Usual Occup   | ation  |  | 16b. Kind o  | of Business/   | Industry   |
| 'nat<br>edica  | Completed   | 15. Decedent's Ed<br>(Specify only highest gra   | ide completed)   | (Give   | kind of work done of DO NOT use retired  | during most of wo<br>d)  | rking  | Med:   |  | auc.ry   |
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| other<br>Jent, th  | BeC   | 17. Father's Name (First, Middle, Last   | )  |   |  |  | me (First, Middle,   |  | name)  |  |
| Mental<br>rked c   | TO E  | Unknown Han  |  |   |  | Unknow   | n Kar  | <b>n</b> g   |  |  |
| of Health and Ment   | 1   | 19a. Informant's Name/Relationship (   | ••   |   | ng Address (Street   |  |  |  |  |  |
| ealth<br>m 27<br>ner tr  |   | Cyril Shin (Son  |  |   | 1 Janney   |  | Date UNK.  |  |  | nd 21 029 Town, State  |
| if ite   |   | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 5  | removal from State 1   |   | osition (Name of<br>ematory or other place   | ce)  | Date UTIN.   |  | •  |  |
| tant:  |   | 4 □ Donation 5 □ Other (Specia   | ,,   |   | ily Cem.  2. Name and Addre  | on of English  | Ruck Tou   |  | n Kore   |  |
| permit. Fages in Department of H Important; If Ite any Injury or ot once.  |   | 21. Signature of Funeral Service Lice  | nsee   | 2   | Z. Name and Addre  |  |  |  | 21 1C + C +  |  |
| 1 L Z & O  | - 1   |  |  | /   |  |  |  |  | nd 2   | •  |
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|  |   | 23a. Part1. Enter the disease, or comshock, or heart failure. List only  | one cause on each line.  | . Do not en   | 1050 York<br>ater the mode of dylr   | Road, T  | owson, Μ   | arylar   | nd 2   | 21204 Approximate Interval Between   |
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State

Registrar

DR. TARIQ MAHMOOD
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

3725

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|                            |  |                | For State   | State of Marylan  |                        | partment of Herenation of Electrificate of L                                      |                                   | d Ment       | al Hygier<br>Reg. I                 | C U 11 1                             | 25335  |
|----------------------------|--|----------------|---|---|------------------------|---|-----------------------------------|--------------|-------------------------------------|--------------------------------------|--|
|                            |  |                | Registrar  1. Decedent's Name (First, Middle, Las   |   | - 1                    | 07111100110 07 2  | -                                 |              | ate of Death                        | Day / Year                           | 3. Time of Death                                     |
|                            | Physicia<br>/Medic   | al             | MARGARET  | THOMPS  | 30N                    | 4b. City, Town, or  | Location of De                    |              | OR                                  | 4c. County of Dea                    | 11:02 pt   |
|                            | Examin   | er             | 4a. Facility Name (If not institution, give   | Street and number)  | B                      | EDGEW   | ATER                              | 3.4          |                                     | ANDE A                               | PUNDEL   |
| T                          | Funeral  |                | 5. Social Security Number 6. Se   | 7. Age (In yrs.   | last birtho            | Months   Davs   | f Under 24 h<br>Hours N           | Hrs. 8. D    | ate of Birth<br>fonth, Day, Yes     | 9. Bir                               | thplace (State or Foreign ountry)                    |
|                            | Director   |                | Usual Residence of Decedent   | . 00  |                        |   |                                   | 0            | 1-30-                               | 1101                                 |  |
|                            | Maryland -f show   | ō              | 10a. State 10b. County  | A D L. Del  | y, Town o              | r Location  |                                   |              |                                     |                                      | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No               |
|                            | r 28a-f  | Director       | 10e. Street and Number  | ARYNDEC /   | [NN]                   | 10f. Zip Code   |                                   |              | 10g.                                | Citizen of What C                    | ountry?  |
|                            | death with the<br>ms 23a or 28a  | ralD           | 701 GLENWS  |   |                        | 2 Man Donadant of Hi  | 1401                              | 2 (Specify ) | Yes or No-                          | 14. Race - Am                        | erican Indian  |
| 0                          | after de<br>or Items<br>niner n  | Funeral        | 11. Marital Status 1 X Never Married 2 ☐ Married  | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 ☒ No                         | .5.                    | <ol> <li>Was Decedent of Hi<br/>If Yes, specify Cuba</li> <li>Yes 2 No</li> </ol> | n, Mexican, Po                    | uerto Ricar  | n, etc.)                            | Black, Whi                           |  |
| 5-003 <del>6</del>         | thin 72 hours after death with the Marylan<br>e. e.<br>n'natural; or Items 23a or 28a-1 show<br>Madical Examiner must be rediffed at   | d by           | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:  | 16a D                  | ecedent's Usual Occupa  |                                   |              | 16h                                 | . Kind of Business                   | LACK   |
| -c [7                      | within 72<br>ene.<br>than "nat<br>he wedic   | Completed      | 15. Decedent's Ed<br>(Specify only highest grant<br>Elementary/Secondary (0-12)                 | de completed)  College (1-4or 5+)   | 10                     | live kind of work done of<br>fe. DO NOT use retired                               | luring most of                    | working      | 1.52                                |                                      | ,  |
| 7                          | filed with<br>Hygiene<br>other the   |                | 12th  17. Father's Name (First, Middle, Last)   | 0   | (                      | Counselor   | 18. Mother's                      | Name (Fir    | Dej<br>st, Middle, Maid             |                                      | t of Aging   |
| Maryland                   | d is d   | To Be          | Selman Porter 5   | Thompson  |                        |   |                                   |              | s Hol                               | _                                    |  |
| lary                       | 2 should<br>and Men<br>is marke<br>aumatic   | -              | 19a. Informant's Name/Relationship (7   | ype, Print)   |                        | lailing Address (Street a   | and Number o                      | r Rural Ro   | ute Number, Ci                      | y or Town, State,                    |  |
|                            | 1 and<br>Health<br>em 27<br>ther t   |                | Alice Ennals(N: 20a. Method of Disposition  |   | _                      | )7 Buskin<br>isposition (Name of<br>Crematory or other plac                       |                                   | Gler         |                                     | Le, Md.<br>Location - City o         |  |
| altimore,                  |  | 8              | 1 🕅 Burial 2 □ Cremation 3 □  1 □ Cremation 5 □ Other (Specify                                  | Hemoval from State   Mc   |                        | ial Garden  | ns   8-                           | -10-0        | )7 Da                               | avidson                              | ville, Md.   |
| Balti                      | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.   |                | 21. Signature of Funeral Service Licen  | see MCO4  | 82                     | WmwameReAgage<br>821 West   |                                   |              |                                     | _                                    |  |
|                            | 20244  |                | 23a. Part1. Enter the disease, or complete shock, or heart failure. List only                   | olications that caused the dear   |                        |   |                                   |              |                                     | Mu. ZI                               | Approximate<br>Interval Between                      |
| =                          | Priysician   | 1              | Immediate Cause (Final disease or condition   | C.V.Y   | 7. (                   | Ceretino l  | lasula                            | er A         | cciden                              | <u>+ )</u>                           | Onset and Death                                      |
| ı                          | /Medical<br>Examiner   |                | resulting in death)   | Due to (or as a consec  |                        |   |                                   |              |                                     |                                      |  |
|                            | n =  | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying              | b. Due to (or as a consec   | quence of)             | 301)  |                                   |              |                                     |                                      |  |
| Sp                         | xecutec<br>and<br>II-transi  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as a consec   | quence of)             |   |                                   |              |                                     |                                      | -  |
| 8760,                      | ficate be executed<br>physician and<br>is the burial-transit   | dical          |   | . d   |                        |   |                                   |              |                                     |                                      |  |
| 9                          | ertifica<br>Jing ph<br>se as th  | w              | IF FEMALE:  | 23c. If yes, outcome of pregn   | ancv                   |   |                                   |              |                                     | 23d. Date of d                       | elivery  |
| Box                        | The law requires that the death certific ate has been signed by the attending plage 2 should be detached for use as  | Physician/M    | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No                                | 1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of a                                  | al death               | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)   |                                   |              |                                     | Month                                | Day Year   |
| 0.0                        | that the de<br>ed by the a<br>detached   | Phys           | 9 ☐ Unknown  Part II. Dther significant conditions of   | 9☐ Unknown  | sulting in t           | he underwing cause giv  | en in Part I                      | -            | 23e. Did tobac                      | co use contribute                    | to the cause of death?                               |
| ds,                        | w requires that<br>been signed I<br>should be det  | d by           | Fait II. Date: significant conductions  | onthibuting to doubt but not re-  | January III v          |   |                                   | _            | 1 🗆 Yes                             | 2 🗹 No 3 🗆 F                         | Probably 4 Unknown                                   |
| ecor                       | law req<br>as beer<br>2 shou   | Completed      |   |   |                        |   |                                   | _ 1          | 24a. Was an<br>autopsy              | 24b. Were a                          | autopsy findings available<br>completion of cause of |
| ž<br>z                     | t: The licate ha   |                |   |   |                        |   |                                   |              | performed<br>1 ☐ Yes 2 ☑            |                                      | os 2 No  |
| Ž                          | Physician:<br>r this certifica<br>ral director, i  | o Be           | 25. Was case referred to medical examiner? 1  Yes 2 No  | Hospital: 1 ☐ Inpatient 2 ☐   | ] ER/Outp              | atient 3 DOA Oth  |                                   |              | eck only one)<br>5 □ Residenc       | e 6 □Other (Sp                       | ecity)   |
| בֿ                         | Ing Ph   | on; T          | 27. Manner of Death 1 ☑Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Tir<br>Inje       | ury Wor   | yat<br>k?<br>Yes 2 □ No           |              | Describe how                        | njury occurred                       |  |
| Division of Vital Records, | Attending<br>or death.<br>ector: Atler<br>by the fune  | Certification; | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined                  | e 28e. Place of Injury - At h   |                        |   | 163 2 110                         | 28f.         | Location (Stree<br>City or Town, S  |                                      | Rural Route Number,                                  |
| á                          | Ital or A  |                |   | building, etc. (Speci   |                        |   |                                   | d            |                                     |                                      |  |
|                            | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medicai        | 29a. Certifier 1 ☐ Certifying Ph<br>(Check only 2 ☐ Medicel Exer                                | nysician: To the best of my kn<br>niner: On the basis of examin<br>and manner stated. | owledge,<br>ation and/ | death occurred at the tir<br>or investigation, in my o                            | ne, date and p<br>pinion, death ( | occurred a   | due to the caus<br>t the time, date | e(s) and manner<br>and place, and di | is stated.<br>Je to the cause(s)                     |
|                            | To the within To the complete  | Me             | 29b. Signature and title of certifier   | c 870 -   | ar                     | 29c. Licens   |                                   | 53           | 29d.                                | Date signed (Mo.                     | _  |
| ,                          |  |                | 30. Name and address of person who  |   |                        | 3   | 506<br>an                         |              | SUMB,                               | , (                                  | 007  |
|                            | 2  |                | 58H Dec   | ale Church  | 1 bon                  | Ru.   | dear                              | ie 1         | MD                                  | 20751                                |  |
|                            | Sta<br>Regist  |                | 31. Date filed (Month, Day, Year)  AUG 1 6 2007   | 32. Registrar's Sign  | ature                  |   |                                   |              |                                     |                                      |  |
|                            |  |                | MAM - 0 FOOL  | Real Property and   |                        |   |                                   |              |                                     |                                      |  |

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician: funeral

Baltimore, Maryland 21215-0036

Pages 1 and 2

or Attending n 24 hours after death.

• Funeral Director: A pletely filled in by the fu completely the

Certification:

Medical

2

State

Susan JHenleyMD

2007

6 Could not be determined

29c. License number D43591

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1190 W. Northern Pkwy #101 Baltimore Maryland 21210

31. Date filed (Month, Day, Year) AUG1 6

29b. Signature and title of certifier

2 Accident

4 ☐ Homicide

3 ☐ Suicide

29a. Certifier

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                  |  |                  | For   | State of Maryl                                    |                              | rtment of F<br>tificate of                                    |                         | d Menta         |                                | 1 1 1 1 1 1 1                   | die and a                                     |
|------------------|--|------------------|---|---|------------------------------|---|-------------------------|-----------------|--------------------------------|---------------------------------|---|
|                  | _  |                  | Registrar  1. Decedent's Name (First, Middle, La  | nst)  | 061                          | inicate or i  | Death                   |                 | Reg. N                         |                                 | 3. Time of Death                              |
|                  | Physicia   | an               | Pauline   | ,   |                              | Wallac  | e                       | Augu            |                                | 4 2007                          | 12:55p <sup>M</sup>                           |
|                  | /Medic<br>Examin   | _                | 4a. Facility Name (If not institution, gi   | ve street and number)                             |                              | 4b. City, Town, o   |                         |                 |                                | c. County of Death              |   |
|                  |  |                  | Gilchrist Nur   | sing Home   |                              |   | wson                    |                 |                                | Baltin                          |   |
|                  | Funeral  |                  |   | 1 M WTE   | yrs. last birthday)<br>Yrs.  | If Under 1 Year<br>Months Days                                |                         | Min. (Mor       | of Birth<br>oth, Day, Yea      | r) 9. Birthp<br>Coul            | olace (State or Foreign<br>ntry)<br>GA        |
|                  | Director   | -                | 232-98-9602 Usual Residence of Decedent   | 79  |                              |   |                         | 01              | 29_2                           | 20                              | GA  |
|                  | yland<br>how<br>at   | . [              | 10a. State 10b. County  | 10c.  | City, Town or Lo             | cation  |                         |                 |                                |                                 | 10d. Inside City Limits                       |
|                  | e Mai<br>3a-f si   | cto              | MD Hov  | vard  |                              | Columbia  | <u> </u>                |                 |                                |                                 | 1 Yes 2 No                                    |
| 2/2              | vith th  | Dire             | 10e. Street and Number  |   |                              | 10f. Zip Code   | 0.45                    |                 | 10g. C                         | Citizen of What Cou             |   |
| 0/2              | sath v   | era              | 5606 High Tor   | H111<br>12. Was Decedent Ever i                   | n U.S. 13 V                  | 1   | LO45                    | ? (Specify Yes  | or No-                         | U.S.A.                          |   |
| EQ."             | fter de<br>ritem<br>iner r   | Funeral Director | Never Married 2 Married   | Armed Forces?<br>1 ☐ Yes 2 ☑ No                   |                              | Was Decedent of H<br>f Yes, specify Cub                       |                         | uerto Rican, e  | tc.)                           | Black, White,                   | etc.  |
| 036              | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23a or 28a-f show<br>he Medical Examiner must be notified at   | þ                | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:                    |                              | I∐Yes 2[X]No  | Specify:                |                 |                                | Specify: B                      | lack  |
| 5-003            | 72 hc<br>'natu   | Completed        | 15. Decedent's E<br>(Specify only highest g   | Education<br>rade completed)                      | 16a. Deced                   | lent's Usual Occup<br>kind of work done<br>DO NOT use retired | ation<br>during most of | f working       | 16b.                           | Kind of Business/In             | dustry  |
| 121              | within<br>ene.<br>than '   | gu               | Elementary/Secondary (0-12) 6th grade   | College (1-4or 5+)<br>na                          | nie. i                       | N/A   | J)                      |                 |                                | N/A                             |   |
| 200<br>d 21      | filed<br>Hygid<br>Sther<br>ent, th   | Be Co            | 17. Father's Name (First, Middle, Las   |   | 1                            | IV/ IV  | 18. Mother's            | Name (First,    | Middle, Maide                  |                                 |   |
| 14. 2<br>aryland | Jid be<br>Jental<br>rked<br>rked<br>tic ev   | To B             | Eddie Wallace   | Dr.   |                              |   | Ethe                    | r Higo          | gins                           |                                 |   |
| 1<br>lary        | 2 shou<br>and N<br>is ma<br>auma   |                  | 19a. Informant's Name/Relationship  |   | I                            | •   |                         |                 |                                | or Town, State, Zi              | •   |
| Z,               | and sealth m 27  |                  | Thomas Wallace  | SrBroth   |                              |   |                         | ill, O          |                                | bia, Md<br>Location - City or T |   |
| US7<br>more,     | iges 1<br>it of H<br>if ite<br>or ot   |                  | 20a. Method of Disposition 1   Burial 2 □ Cremation 3   |   |                              | sition (Name of matory or other pla                           |                         |                 |                                | eenbrier                        |   |
|                  | perriit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  |                  | 4 Donation 5 Other (Spec<br>21. Signature of Funeral Service Lice   |   |                              | Mem. Ga   |                         |                 | O/ GE                          | eenprie                         | ., , ,  |
| Z Ba             | permi<br>Departiment<br>Important<br>any Ir  |                  | Mu  | 5 Keke  | Ma<br>43                     | Name and Address F/H  | H West<br>Ash Av        | e, Ba           | ltimo                          | re, Md                          | 21215   |
|                  |  |                  | 23a. Parl1. Enter the disease, or co  | mplications that the divine cause on each line.   | death. Do not ent            | er the mode of dyi  | ng, such as ca          | rdiac or respir | atory arrest,                  |                                 | Approximate<br>Interval Between               |
|                  | Physician  | Ш                | Immediate Cause (Final disease or condition   | LUNI  | CANO                         | ER  |                         |                 |                                |                                 | Onset and Death                               |
|                  | /Medical<br>Examiner   |                  | resulting in death)   | Due to (or as a c                                 | nsequence of):               |   |                         |                 |                                |                                 |   |
|                  | Lxammer  | <u>_</u>         | Sequentially list conditions,   | b. Due to (or as a cor                            | nsequence of):               |   |                         |                 |                                |                                 |   |
|                  | uted<br>I<br>ansit   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Little fundering Cause (Disease or injury that initiated events | _   | ,                            |   |                         |                 |                                |                                 |   |
| o,               | ficate be executed<br>physician and<br>s the burial-transit  |                  | resulting in death) Last  | Due to (or as a cor                               | sequence of):                |   |                         |                 |                                |                                 |   |
| 8760,            | ate be<br>hysicii<br>the bu  | dical            |   | d   |                              |   |                         |                 |                                |                                 |   |
| 9                | ertification of the seas to th | /Mec             | IF FEMALE:  | 23c. If yes, outcome pf pr                        | egnancy                      |   |                         |                 |                                | 23d. Date of deliv              |   |
| Вох              | death certifi<br>e attending<br>d for use as   | Physician/Me     | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No   | 1□Live birth 2□<br>4□Pregnant at time             | Fetal death 3                | Ectopic pregnanc Other (specify)                              | у                       |                 |                                | Month                           | Day Year                                      |
| o.               | the d  | ysi              | 1 ☐ Yes 2 D No<br>9 ☐ Unknown   | 9□Unknown   |                              |   |                         |                 |                                |                                 |   |
| J. ".            | w requires that the death certif<br>been signed by the attending<br>should be detached for use as  | by Pi            | Part II. Other significant conditions   | contributing to death but no                      | t resulting in the u         | nderlying cause giv   | ven in Part I.          | 23              | e. Did tobacc                  | V.                              | the cause of death?                           |
| Z ž              | requires<br>een sign<br>oould be   | ed k             |   |   |                              |   |                         |                 | 1 ☐ Yes                        | 2No 3□ Pro                      | bably 4 Unknown                               |
| 77               | 2 3 2  | Completed        |   |   |                              |   |                         | 24              | a. Was an<br>autopsy           | 24b. Were aut<br>prior to co    | opsy findings available ompletion of cause of |
| Z = =            | That are pag   | S                |   |   |                              |   |                         | 1[              | performed<br>Yes 2             | ? death?<br>No 1 ☐ Yes          | 2 □ No  |
| Vit.             | sician: Th<br>certificate<br>rector, pag   | Be               | 25. Was case referred to medical examiner?  1 ☐ Yes   | Hospital:   | 2 ☐ ER/Outpatie              | -t all pos Ott  |                         | f Death (Chec   |                                | A 1701 - 170                    | ity HOSPICE                                   |
| 20               | Phys<br>ar this<br>aral di   | - T              | 1 ☐ Yes 2000<br>27. Manner of Death   | 28a. Date of Injury                               | 28b. Time o                  | " 3 DOW   | 4 LI Nurs               |                 |                                | njury occurred                  | my WOO 12                                     |
| <u>5</u>         | tending P<br>death.<br>stor: After i   | atio             | 1 atural 5 Pending investigati  |   | ar) Injury                   |   | Yes 2 No                |                 |                                |                                 |   |
| √ Nisi           | l or Attendafter death   | Certification:   | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine   |   | At home, farm, st<br>pecify) | reet, factory, office   |                         | 28f. Loc<br>Cit | ation (Street<br>y or Town, St | and Number or Ru<br>ate)        | ral Route Number,                             |
| To               | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.   | Cer              | 29a. Certifier  | Physician: To the best of my                      | rknowledge deel              | h occurred at the   | ime date and            | place and dur   | e to the cause                 | e(s) and manner as              | stated  |
| 2                | To the Hospital of within 24 hours at To the Funeral D completely filled i   | Medical          |   | aminer: On the basis of exa<br>and manner stated. |                              |   |                         |                 |                                |                                 |   |
|                  | To the<br>within<br>To the   | Me               | 29b. Signature and title of certifier   | 197   | .,                           | 29c. Licen  |                         |                 |                                | Date signed (Month              |   |
|                  |  |                  |   |   | ~»                           |   | 6439                    | 15              | Au                             | gust 14                         | 2007  |
|                  | 4  |                  | 30. Name and address of person who DAN/EWE DOBE 31. Date filed (Month. Day, Year)   | o completed cause of death                        | (Item 23a) (Type,            | Print)  | SCTS                    | SUITE S         | 16.7                           | DWSON.                          | UD 21204                                      |
|                  | Str  | ate              |   | 32 Registrar's                                    | Signature                    | عد مد م   | 02110                   |                 | + 11                           |                                 |   |
|                  | Pariet   | ror              | AUG 1 6   | 2007  | 1. A.                        | 23366   |                         |                 |                                |                                 |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #26, perverb. 6870, 8/16/07 Ticertificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) :47Am August **Physician** Villiam 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Façility Name (If not institution, give street and number) Examiner Baltimore Hopkins Hospita lohns | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day) 7. Age (In yrs. last birthday) 24 Yrs. 9. Birtholace (State or Foreign **Funeral** Months Marylana 12 M 2□ F 218-02-3767 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland ind Mental Hygiene. s marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21213 USA alk 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1□Yes 2☑No Specify: Black Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Decement's Oscial Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Kestaurant 18. Mother's Name (Firşt, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be h and Mental William niant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an Belair mother RD Knight BALTO. 21313 item 27 Emma MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 8-16-07 Dundalk, mD 4 ☐ Donation 75 ☐ Other (Specify) uneral Home P.A 21. Signature of Funeral Service Licens 21229 Baltimore MD Fredhilton Pass of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Fa 1 Ent r the dis sinck, of heart failt Immedia Cause (Final ardiovascular www **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner pertension Sequentially list no office, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of death? perform 2 No 1 ☐ Yes this certificate 2 No or Attending Physician; 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Medical Certification: To Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2X ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury the funeral 27. Manper of Death 28d. Describe how injury occurred 28c. Injury at Work? After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death. Director 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0058860 | August 16, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTU, MI) 3333 N. Calvert. Street, suitesss SHAUN

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

AUG

32. Registrar's Signature

PRINCE

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

|          |   |                | 1 - For<br>State<br>Registrar  | State of Marylar   |                                | tificate of                             |  |                                      | g. No.                     |                            |  |
|----------|---|----------------|--|--|--------------------------------|---|--|--------------------------------------|----------------------------|----------------------------|--|
|          | Physicia  |                | 1. Decedent's Name (First, Middle, L   | ast)   |                                |   |  | Date of Death     Month              |                            | ear 3                      | . Time of Death                        |
|          | /Medic  |                | Louis Webster  |  |                                |   |  |                                      | 9 2007                     |                            | 12:20 P <sup>M</sup>                   |
|          | Examin  |                | 4a. Facility Name (If not institution, gi  | ve street and number)  |                                | 4b. City, Town, o                       | r Location of Death                    |                                      | 4c. County of              |                            |  |
|          |   |                | 7 Willow Way   |  |                                | Berl:                                   | in                                     |                                      | Worces                     | ter                        |  |
|          | Funeral   |                | Social Security Number 6.  | Sex 7. Age (In yrs.  |                                |   | If Under 24 Hrs.<br>Hours Min.         | 8. Date of Birth<br>(Month, Day,     | 9                          |                            | (State or Foreign                      |
|          | Director  |                | 213-09-1457  | 1 <b>∑</b> M 2□F 92  | Yrs.                           | Months Days                             | Tiours   Willi,                        | Oct. 30                              | ,                          |                            | 'land                                  |
|          | pu ,  |                | Usual Residence of Decedent  | 10- 0  | 4. T                           |   |  |                                      | O 7 1 3 1 4                |                            |  |
|          | show  | _              | 10a. State 10b. County   | 10c. Ci  | ty, Town or Lo                 | cation                                  |  |                                      |                            |                            | Inside City Limits                     |
|          | e Marf s  | 5              | Maryland Wor   | cester   |                                | Ве                                      | erlin                                  |                                      |                            |                            | 1 ☐ Yes 2 ☑ No                         |
|          | or 2%   | Director       | 10e. Street and Number   |  |                                | 10f. Zip Code                           |  | 10                                   | g. Citizen of Wha          | t Country?                 |  |
|          | 23a<br>ust b  | اع             | 7 Willow Way   |  |                                |   | 21811                                  |                                      | United                     | State                      | :S                                     |
|          | hours after death with the Maryland<br>tural", or items 23a or 28a-f show<br>al Examiner must be notified at  | Funeral        | 11. Marital Status   | 12. Was Decedent Ever in L<br>Armed Forces?  | J.S. 13. \                     | Vas Decedent of H                       | ispanic Origin? (Span, Mexican, Puerto | ecify Yes or No-                     | 14. Race -                 | American II<br>White, etc. | ndian,                                 |
| ٥        | afte<br>or it<br>min  |                | 1 Never Married  Married   | 1 ☐ Yes 2 <b>½</b> No<br>If Yes, Give  |                                | l □ Yes 21 No                           |  | 1110411, 0101,                       |                            | winte, etc.                |  |
| 5-0036   | ours<br>Fxa   | d by           | 3 Widowed 4 Divorced   | Year or Dates:   |                                | 22110                                   | opcony.                                |                                      | Specify:                   | Whi                        | te                                     |
| ה        | i 72 hours after death with the Marylar<br>"natural", or ftems 23a or 28a-f show<br>edical Examiner must be notified at   | Completed      | 15. Decedent's E<br>(Specify only highest g  | Education rade completed)  | 16a. Deced                     | lent's Usual Occup                      | ation<br>during most of work<br>f)     | ina 1                                | 6b. Kind of Busin          | ess/Industr                | ry                                     |
| 7        | ithin<br>nan '  | 면              | Elementary/Secondary (0-12)  | College (1-4or 5+)   | life. L                        | OO NOT use retired                      | 1)                                     |                                      |                            |                            |  |
| N        | ygiel<br>ygiel<br>rt, th  | 3              | 8 Years  |  | Cra                            | ne Operat                               |  |                                      | Steel I                    | ndust                      | ry                                     |
| yland    | be fill H d oth   | Be             | 17. Father's Name (First, Middle, Las  | , and a second s |                                |   | 18. Mother's Name                      | e (First, Middle, Ma                 | ,                          |                            |  |
| <u>8</u> | Men<br>arke<br>atic   | ၉              | George Turner  |  |                                |   |  | Cindy Be                             |                            |                            |  |
| Mar      | permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. |                | 19a. Informant's Name/Relationship Mrs. Brenda Arch  | (Type, Print) G-Daught   | 9b. Mailin                     | g Address (Street                       | and Number or Run                      | al Route Number,                     | City or Town, Sta          | ite, Zip Cod               | de)                                    |
| e,       | and<br>ealth<br>n 27<br>ner tr  | - 1            | MIS. DIENGA AICI   |  |                                | bin Hood                                |  | Berlin, M                            | Maryland                   | 218                        | 11                                     |
| 916      | of H  |                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [  | ZRomoval from State  | Place of Disposicemetery, cren | sition (Name of<br>natory or other plac | ce) [                                  |                                      | 0c. Location - Cit         |                            |  |
| baltimor | Pag<br>nent<br>ant: I   |                | Donation 5 Other (Spec   |  | eadowri                        | dae Mem.                                | Park 8/1                               | 3/2007                               | Elkride                    | 10 M-                      |  |
| a        | porti<br>porti<br>y Inj   |                | 21. Lignature of Funeral Service Lice  | ee O   | 22                             | . Name and Addres                       | ss of Facility                         | 50                                   |                            |                            |  |
| מ        | 8 9 7 E 8   | 1              | NEC  | ( a)()   |                                |   | Funeral                                |                                      |                            |                            |  |
|          |   | 9              | 23a Part I. Enter the disease, or cor<br>shock, or heart failure. List only  | nplications that caused the dear   | th. Do not ente                | er the mode of dyin                     | g, such as cardiac                     | or respiratory arres                 | st,                        | App                        | proximate<br>erval Between             |
|          | Physician   |                | Immediate Cause (Final disease or condition  | a. ATTEROSCL   |                                |   |  |                                      |                            | On                         | set and Death                          |
|          | /Medical  |                | resulting in death)  | a. Due to (or as a consec  | quence of):                    | CHACINO                                 | VIII                                   | 1201                                 | 121/1-                     |                            |  |
|          | Examiner  |                |  | Iter Pa  | TENS                           | coin                                    |  |                                      |                            |                            |  |
| U.       | 1   | je l           | Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a consec   |                                |   |  |                                      |                            |                            |  |
|          | uted<br>d<br>ansit  | 直              | Cause (Disease or injury that initiated events   | ^  |                                |   |  |                                      |                            |                            |  |
| <u></u>  | tificate be executed<br>ig physician and<br>as the burial-transit   | Examiner       | resulting in death) Last   | Due to (or as a consec   | quence of):                    |   |  |                                      |                            |                            |  |
| 00/00    | le be<br>/sicia<br>e bui  | हु             |  | ►d.  |                                |   |  |                                      |                            |                            |  |
| 00       | ifficat<br>g phy<br>as th   | ledical        |  |  |                                |   |  |                                      |                            |                            |  |
| ×        | Se din Se   |                | IF FEMALE;<br>23b. Was decedent pregnant   | 23c. If yes, outcome pf pregn  |                                |   |  |                                      | 23d. Date of               | delivery                   |  |
| Ď        | death<br>a atte   | cia            | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 1 Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of o   |                                | Ectopic pregnancy<br>Other (specify)    |  |                                      | Month                      | Day                        | Year                                   |
| į        | the (   | Physician/N    | 9□Unknown  | 9□Unknown  |                                |   |  |                                      |                            |                            |  |
| <u>_</u> | that<br>ned b   |                | Part II. Other significant conditions  | contributing to death but not res  | ulting in the un               | derlying cause give                     | en in Part I.                          | 23e. Did toba                        | icco use contribu          | te to the ca               | ause of death?                         |
| 3        | uires<br>n sign   | d by           |  |  |                                |   |  | 1 ☐ Yes                              | 2 No 3                     | Probably                   | 4 □Unknown                             |
| cords,   | The law requires that the death ate has been signed by the atten bage 2 should be detached for u  | Completed      |  |  |                                |   |  |                                      |                            |                            |  |
| ב<br>ב   | has<br>has  | 립              |  |  |                                |   |  | 24a. Was an<br>autopsy<br>performe   | prior                      | to comple                  | findings available<br>tion of cause of |
|          |   | Ŝ              |  |  |                                |   |  |                                      |                            | n?<br>Yes 2□               | l No                                   |
| T        | hysician: The law<br>his certificate has b<br>I director, page 2 sl   | Be             | 25. Was case referred to medical examiner?   | Lippoital  |                                | T <sub>au</sub>                         |  | Check only one)                      |                            |                            |  |
| 5        | Physician:<br>rthis certific<br>ral director,   | ို             | 1 Yes 2 No   |  | ER/Outpatient                  |   | 4 LI Nursing Ho                        | me 5∐ Residen                        | ce 6 Other (               | Specify)                   |  |
|          | ding F  | ë              | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury         | 28c. Injun<br>Work                      | y at<br>c?                             | 28d. Describe how                    | injury occurred            |                            |  |
| 2        | tend<br>eath.<br>or: /<br>the f   | Sati           | 2 Accident investigation 3 Suicide 6 Could not be  |  |                                | M 1 1 1                                 | Yes 2 □ No                             |                                      |                            |                            |  |
| 2        | or At<br>ter d<br>irect<br>irect  | Certification: | 4 Homicide determined  |  | ome, farm, stre<br>fy)         | et, factory, office                     |  | 28f. Location (Stre<br>City or Town, | et and Number of<br>State) | r Rural Ro                 | ute Number,                            |
| ב        | ral o   |                |  |  |                                |   |  |                                      |                            |                            |  |
|          | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral   | ca             | (Check only 2 Medical Exa  | hysician: To the best of my kno<br>miner: On the basis of examina  | owledge, death                 | occurred at the tin                     | ne, date and place,                    | and due to the cau                   | ise(s) and manne           | er as stated               | d.                                     |
|          | the I   | Medical        | 0,10,  | and manner stated.   |                                |   |  |                                      |                            |                            |  |
|          | Vait vait   | 2              | 29b. Signature and title of centifier  |  | >                              | 29c. License                            | number                                 | 290                                  | d. Date signed (N          | lonth, Day,                | Year)                                  |
|          | / }   | -              | ( and  |  |                                | 1.16                                    | teses +                                | 1                                    | 8.9.                       | 1.00                       | 4                                      |
|          | 2   |                | 30. Name and address of person who   |  |                                |   |  | _                                    |                            |                            | ,                                      |

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Hegistrar's Signature

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day Year **Physician** 9:00 12 2007 WEINREICH AUDREY AUGUST /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Co Dundalk 4124 Beachwood Road 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🖾 F 3,1915 92 Director 212-34-4535 Usual Residence of Decedent the Manyland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County 28a-f show other traumatic avant, the Medicul Exercit at must be notified at Dundalk 1 □Yes 2 No Baltimore Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code ā United States 21222 itams 23a Beachwood Road 4124 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 72 hours after 1 □ Never Married 2 □ Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ White 3 ☑ Widowed 4 □ Divorced "naturai". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 72 h and Mental Hygiene." 7 is marked othar than "n Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ethel Leotta Fetrow Andrew Oswald Krouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an ant: If itam 27 is 4124 Beachwood Road Dundalk, Maryland 21222 (Daughter) Linda Mueller 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If its any injury or or once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/16/2007 Baltimore, Maryland Oak Lawn Cem. \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a CONGESTIVE HEART FAILURE YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit and Due to (or as a consequence of): the attending physician hed for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, COPONARY ARTERY DISEASE, ATRIAL FIBRILLATION 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPERTENSION, DEMENTIA certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death al or Attanding P after death. I Diractor: After ( 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide Hospital c To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AUGUST 13 2007 D62032 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SSOS HOPKING BAYVIEW CIRCLE, BALTIMORE JENNIFER 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Good

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 8:40 P M August 13, 2007 Charles Kenneth Wilson Sr /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number 6. Sex 1 **4**M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours **Director** 216-30-7985 73 Maryland May 16, 1934 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits notified at Director 1 ☐ Yes 2X No Maryland Harford Bel Air 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 1908 Ruffs Mill Road 21015 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2√ No If Yes, Give 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Specify: Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 212 Elementary/Secondary (0-12) College (1-4or 5+) 8 Carpenter Construction 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) James Smithson Wilson Dasey Marie Smithson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley D. Wilson / Wife 1908 Ruffs Mill Road, Bel Air, Maryland 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gdn 8-16-07 | Aberdeen, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part . Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** DISCOR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐Ectopic pregnancy Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) . 16444.

Registrar
DHMH 17 Rev 1/2001

10

State

602

S. ATWOODRD. BELAIR MD21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

VIJAY S. NAIR

AUG 1 6

31. Date filed (Month, Day, Year)

M.D

Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Robert | Talylor | Weeks, | Jr. |  |
|--------|---------|--------|-----|--|
|--------|---------|--------|-----|--|

| •   |   | 1              | - For State  | Cer  | tificate of De                              |                          |  |                                | . No.                                |  |
|---|---|----------------|--|--|---|--------------------------|--|--------------------------------|--------------------------------------|--|
| Phy   | sicia   |                | Registrar  1. Decedent's Name (First, Middle,Last)             |  | _   |                          |  | 2. Date of Death               | Day Year                             | 3. Time of Death                                     |
| Vr⁻"nal Ex  | camir   |                | Robert Taylor Wee  |  |   |                          |  | August 5, 2                    | 007                                  | 0040 hrs   |
|   |   |                | 4a. Facility Name (if not institution, give str                | reet and number)                           |   | ity, Town, or<br>asadena | Location of Death                        | 1                              | 4c. County of Deat<br>Anne Arunde    |  |
|   |   | ■.             | 7974 Belhaven Ave.  5. Social Security Number 6, Sex           | 7. Age (In yrs. Ia                         |   | Under 1 Yea              | ar If Under 24Hrs                        | Data of Birth                  | (MM/DD/YYYY) 9. Bi                   |  |
| Fune<br>Direc   |   |                | 226-40-0891 <sup>1</sup> <b>X</b> <sup>M</sup>                 | 2 F 71                                     |   | onths Day                |  | _                              | Forei                                |  |
|   | any   |                | Usual Residence of Decedent  10a. State 10b. County            | 10c. City,                                 | Town or Location                            |                          |  |                                |                                      | 10d. Inside City Limits                              |
|   | \$  |                | MD Anne Arun   | ido1                                       | Pasad                                       | lans                     |  |                                |                                      | 1 Yes 2 X No   |
| arylar  | 28a-f show<br>I at once   | Director       | 10e. Street and Number   | ide1                                       |   | . Zip Code               |  | 109                            | g. Citizen of What Cou               | untry?   |
| the M   | 23a or 2<br>notified  | <u></u>        | 7974 Belhaven Ave.   |  |   | 21                       | 122                                      |                                | USA                                  |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene                    | ns 23<br>be no  | 교              |  | 2. Was Decedent Ever in U.                 |   |                          | spanic Origin? ( S<br>n, Mexican, Puerto |                                | 14. Race - Ame<br>White, etc.        | rican Indian, Black,                                 |
| death   | nust  | Funeral        |  | Armed Forces? Yes 2 No                     |   |                          |  | rican, etc.)                   |                                      |  |
| after   | iner.   | 칡              | 3 Widowed 4 Divorced If Y                                      | Dates:                                     |   | 2 X No                   |  | a a                            |                                      | hite   |
| hours   | Exem  |                | 15. Decedent's Education (Specify only h                       | College (1-4 or 5+)                        | 16a. Decedent's Us<br>during most of        |                          | ation (Give kind of<br>e. DO NOT use ret |                                | 16b. Kind of Business                | rindustry  |
| 36<br>iin 72  | dical dical   | e e            | Elementary/Secondary (0-12)                                    | 0  | Supervi                                     | sor                      |  |                                | General M                            | lotors   |
| -00-<br>d with  | ther t  | Completed      | 17. Father's Name (First, Middle, Last)                        |  | Japozva                                     | 1                        | 18.Mother's Nam                          | e (First, Middle, M            |                                      |  |
| 21215-0036<br>buld be filed within 7<br>Mental Hygiene  | rked other than "natura<br>ent, the Medical Exturin                                   |                | Robert Taylor Wee  | ks. Sr.                                    |   |                          | Ada Dan                                  | e Trump                        |                                      |  |
| ould I  | s mar   | 리              | Robert Taylor Wee  | , Print )                                  | 19b. Mailing Add                            | dress (Stre              | et and Number or                         | Rural Route Numb               | er, City or Town, Stat               | e, Zip Code)   |
| MD<br>nd 2 sho<br>alth and  | tem 27 is n<br>traumatic  | ļ              | Mrs. Diana Weeks /   | Wife                                       | 7974 Be                                     | 1have                    | n Avenue                                 | Pasad                          | ena, Mary1<br>20c. Location - City o | and 21122  |
| s l an  | t: If iter<br>other tra   |                | 20a. Method of Disposition  1 Burial 2 Cremation 3             | Removal from State Ball                    | Place of Disposition<br>cted MtQ/6 Coth & K | amato                    | ry                                       |                                |                                      |  |
| Page<br>nent o  | ant:<br>or oth  |                | 4 Donation 5 Other Specify:                                    | @  | Loudon Pa                                   |                          |  | 13/07                          |                                      | , Maryland   |
| Baltimore,<br>permit. Pages 1 ar<br>Department of He  | Impor<br>injury   |                | 21. Signature of Funeral Service Licensee                      | 0  |   |                          |  |                                | k Funeral                            |  |
|   |   | _              | 23a. Part I. Inter the disease, or complica                    | tions that caused the death                | . Do not enter the mo                       | ) Wilk                   | ens Ave.                                 | Baltimo<br>or respiratory arre | re, Maryla                           | Approximate Interval                                 |
| Physic<br>Med   |   |                | failure. List only one cause on each I                         | ine.                                       |   | ,,,,,                    |  |                                |                                      | Between Onset and<br>Death                           |
| _xami   | iner  |                |  | sanguination to (or as a consequence o     | of):  |                          |  |                                |                                      |  |
|   |   |                |  | lodgement of Centra                        |   | sis Cathe                | eter                                     |                                |                                      |  |
|   |   | ner            | if any, leading to immediate Due cause. Enter Underlying Cause | to (ar as a consequence o                  | r);   |                          |  |                                |                                      |  |
| 0   |   | Examiner       | (Disease or injury that initiated C.                           | to (or as a consequence of                 | of):  |                          |  |                                |                                      |  |
| Med. B  | und<br>transit  |                | d  |  |   |                          |  |                                |                                      |  |
| e exe   | physician and<br>he burial - transit  | Medical        | UNPENDED   | MENDED                                     |   |                          |  |                                |                                      |  |
| <b>760,</b> icate be  | g phys  |                | IF FEMALE: 23b. Was decedent pregnant in the                   | 23c. If yes, outcome of preg               |   | noth 3                   | Ectopic pregn                            | iancy                          | 23d. Date of delive<br>Month         | ry<br>Day Year                                       |
| certif  | s attending pl<br>for use as the  | ciar           | past 12 months?  | Live birth     Pregnant at time of de      |   | eath 3<br>(Specify)      |  | laricy                         | NO.                                  | 55,  |
| Box 687<br>e death certific   |   | Physician/     |  | Unknown                                    |   |                          |  |                                | <u></u>                              |  |
| at the  | > 등   |                | Part II. Other significant conditions co                       |  |   |                          |  |                                | _                                    | o the cause of death?                                |
| D. D  | d be d  | g p            | End stage renal disease, Hy                                    | pertensive atheroscl                       | lerotic cardiova                            | scular dis               | ease,                                    |                                |                                      | obably 4 Unknown                                     |
| v requ  | as been signed be<br>should be deta   | plet           | Prosthetic heart valve, Diabo                                  | etes mellitus                              |   |                          |  | 24a. Was a autops              | y prior to                           | autopsy findings available<br>completion of cause of |
| Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the stafter death.   |   | Completed      |  |  |   |                          |  | perform<br>1 <b>V</b> Yes 2    |                                      |  |
| <u>16</u>   | ctor, 1   | Be             | 25. Was case referred to medical examiner?                     | itali —                                    |   | 26.Plac                  | e of Death (Check                        |                                |                                      |  |
| i, j,   | r this<br>al dire   | 2              | 1 Yes 2 No   | oital: 1 Inpatient 2                       | ER/Outpatient 3                             | DOA                      |  |                                | Residence 6 Oth                      | er: Scene  |
| n ding  | Afte  | ü              | 27. Manner of Death  1 Natural 5 Pending                       | 28a. Date of Injury<br>FOUND:              | 28b. Time of Injury FOUND:                  |                          | ury at Work?<br>Yes 2 ✓ No               | Dislodgemen                    | nt of hemodialysi                    | s catheter   |
| SiO   | ector:<br>by the  | Certification: | 2 Accident Investigation                                       | Aug 5, 2007<br>28e. Place of Injury - At h | 0030 hrs                                    |                          |  | 28f. Location (S               | reet and Number or F                 | Rural Route Number, City                             |
| Divis<br>al or A  | ed in 1   | Ŧ              | 3 Suicide 6 Could not be determined                            | (Specify) Single Far                       |   | otory, office            | bunding, oto.                            | or Town, St                    |                                      |  |
| Di<br>P Hospital<br>24 hours a  | Funeral Director: After this certificate hely filled in by the funeral director, page |                | 4 Homicide  29a. Certifier 1 Certifying Physician:             | To the best of my knowled                  | lge, death occurred a                       | at the time.             | date and place, an                       | d due to the cause             | (s) and manner as sta                | ated.  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. | To the Fu   | Medical        | one) 2 Medical Examiner: Or                                    | the basis of examination a                 | and/or investigation,                       | in my opinio             | n, death occurred                        | at the time, date a            | nd place, and due to                 | the cause(s)   |
| P. Mit  | COI   | Me             | 29b. Signature and title of certifier                          | d manner stated.                           |   | 29c. Licen               | se number                                |                                | 29d. Date signed (M                  | lonth, Day, Year)                                    |
|   |   |                | Dome muince  | of imo.                                    |   | o.c                      | .M.E.                                    |                                | August 5, 2007                       |  |
| ,   |   | ŀ              | 30. Name and address of person who com                         | pleted cause of death (Item                |   |                          | <del></del>                              |                                |                                      |  |
| 5   | XI  |                |  | sistant Medical Exar                       |   | enn Stree                | t, Baltimore, I                          | MD 21201                       |                                      |  |
| D   | St<br>eaist   |                | 31. Date filed (Month, Day, Year)                              | 32. Registrar's Signat                     | ure   | 20                       |  |                                |                                      |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year  $A^{M}$ Ruhu1 Amin July 29, 2007 3:30 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Fort Washington Hospital Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. 1⊠M 2□F Days Hours 080-96-2417 57 Director Bangladesh Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or Items 23a or 28a-f show treumatic event, I've Modical Exeminer must be notified at Prince 1 ☐ Yes 2 No Directo MD George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 Bangladesh death #103 626 Audrey Lane, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Asian 1 ☐ Yes 2 ☑ No Specify: <u>م</u> If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manager Unknown ges 1 and 2 should be filed v t of Health and Mental Hygie If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ayesha Khatun Bodiuzzaman Amin ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 626 Audrey Lane, #103, Oxon Hill, MD Reveya Bhuiyan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State Chandpur Department Importent: If any injury or once. ^ 4 □ Donation 5 □ Other (Specify) 8-5-07 Cemetery Bangladesh 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Islamic Funeral Home 251 DeKalb Avenue, Brooklyn, NY ennes Louis 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 977 ona disease or condition resulting in death) /Medical Que to (or e a consequence of): Examiner once Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated according to the control of the c Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient → ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ٩ 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Medical 29a, Certifier 1 Contifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of confile 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) mD 0 31. Date filed (Month, Day, Year) AUG 0 1 2007 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 2007 8 Bernard Apson 7:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 220 Windjammer Rd. Worcester Berlin 8. Date of Birth (Month, Day, Year) 1/19/1921 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 x M 2 □ F 213-14-8092 Director 86 Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10h County 10d. Inside City Limits Director 1 Tyes 2 TXNo MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d 2 should be filed within 72 hours after death with fin and Mental Hygiene. 77 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 220 Windjammer Rd. 21811 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ★Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify ≥ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 US Government Merchant Marine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Apson ည Dora Kolodzieski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health as
Important: If Item 27 is any injury or a Jane Apson / wife 220 Windjammer Rd., Berlin, MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) Cape Henlopen Crem. 8/2/2007 Frankford, DE 21. Signature Funeral Service Licen 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC Physician LUNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading of immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of be executed Exami burial-tran Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has page 2 autopsy perform Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 ☐ Pending investigation Injury hin 24 hours after death. the Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 1746257 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 103240200CEM CITY CLUD BENERO, MED

Registrar DHMH 17 Rev 1/2001

State

BN 13+1

CASMICDAMO

31. Date filed (Month, Day, Year)

AUG 0 2

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ΪÖ, 2007 Berkowitz 11:05 PM Saul August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Yes 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** <sup>Year)</sup> 1924 1 ☐ M 2 ☐ F Months Days Hours Min. New York 053-18-6307 83 Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14427 Barkwood Drive 20853 U. S. A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1₭ Yes 2□No Army If Yes, Give Year or Dates: WW 2 Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Defense Electrical Engineer 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eva Friedland Samuel Berkowitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau
once. 14427 Barkwood Drive, Rockville, Maryland 20853 Corynne Berkowitz - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/13/2007 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gdns 21. Signature of Funeral Service Licensee Edward SageI Funeral Direction, Inc. 20852 Donald 1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final 5 Days **Physician** Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause, (Disease or nijuly that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) P.0. □Yes 2□No the 9□Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Sepsis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Malnutrition 24a. Was an cate has l autopsy perform certificate 2 No or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐XNo 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dire 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Flural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) +502 11, August 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Carpenter, M. D. 9901 Medical Center Drive, Rockville, Maryland 20850 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG I 2007 6 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Sylvia N. Braver August 7, 2007 /Medical 11:10 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2√€ F 84 August 1, Director 107-18-1809 1923 Poland Poland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified Director 1KTYes 2 □ No NY Nassau North Wocombre the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 835 Talbot Avenue 11581-3111 or items 23a United States of America the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: White 3 ☑ Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If Item 27 Is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Newman Elizabeth "unknown" ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Ehrlich, son 276 Riverside Drive, 9A, New York, NY 10025-5208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 X Removal from State Beth Moses Cemetery 08/09/2007 | Pinelawn, New York 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chaples, Inc. 1170 Rockville Pike, Rockville, Maryland 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSE **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autonsv , page perform certificate To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, f 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

A 0111 Ca/ca/80 Division or Vital Records, P.O. Box 68760. SYLVIA BRANCIA

> 7 State

> > Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TRUONG BAO, 9715 MEDICAL CENTER DRIVE, #201, ROCKVILLE, MARYLAND

1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

2005 7124

29d. Date signed (Month, Day, Year)

81810)

31. Date filed (Month, Day, Year) AUG 1 6 2007

29b. Signature and title of certifier

29a. Certifier (Check only



## Baltimore, Maryland 21215-0036

Physician /Medical Examiner burial-tran Box 68760. the as

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician Month Year WILLIAM **EDWARD** BOONE 2007 03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PLata Year | If Under 24 Hrs. CHARLES Center Birthplace (State or Foreign Country) Age (In vrs. last birthday Date of Birth (Month, Day, **Funeral** Days Hours Year) 1**⊠**M 2□F 220-44-1005 76 Director FEB.7,1931 MARYLAND Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MD CHARLES WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4510 BRYANTOWN ROAD Funeral 20601 S. Α. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1√ Yes 2 No If Yes, Give Year or Dates: 153 — 155 1 Never Married 2 Married 1 ☐ Yes 21 No ģ 3 Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BAILIFF COURT HOUSE is marked other Department of Health and Mental Hy, Important: If Item 27 is marked othany injury or other. injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM MCKINLEY BOONE REBEKAH COMPTON ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTHA F. WORRELL / DAUGHTER 4510 BRYANTOWN ROAD WALDORF, MARYLAND 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. DOMINIC CEMETERY 2007 AQUASCO, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityBRINSFIELD-ECHOLS FUNL.HME., P.A. Basto. M00641 30195 THREE NOTCH RD. CHARLOTTE HALL, MD 20622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) "WK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine XM CHTUS that the death certificate be executed EREVIRA Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for L in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the 9 Unknown 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 17 No certificate has page 2 1□ Yes 2□No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death | Check onl one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) this o 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After Certification: Hospital or Attending 5 ☐Pending investigation 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours ...
o the Funeral Director
`~\*alv filled in by th 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 🗹 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 7 29b. Signatur 29d. Date signed (Month, Day, Year) 30. Name and address of per on who completed cause of death (Item 23a) (Type, Suite 10 reo R9 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Mildred J. Blair 12:35PM 200 WLY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Sunrise Assisted Living-Severna Park Severna Park If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 97 yrs 8. Date of Birth (Month, Day, Year) Apr 24, 1910 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 X F 506-50-8162 Massachusetts Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 X No Director Anne Arundel Severna Park MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 41 West McKinsey Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No <u>8</u> Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Syster Carlstead Charles A. Lindberg 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margery Hafner/ Daughter 200 Sportsman Neck Road, Queenstown, MD 21658 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 30 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Metro Crematory 2007 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eugeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy, Severna Park Funeral Home Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DEMENTIA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA Certification: To

attending physician and for use as the burial-trar

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

**Physician** 

/Medical

Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed

s certificate has b lirector, page 2 s

director

s after deameral Director: Aft

24 hours a

within 24 ho

To the Fund

completely f

filled in by

Medical

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

1 Yes 2 No 27. Manner of Death

5 ☐ Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29c. License number

157531

29d. Date signed (Month, Day, Year) 30,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Veterans

31. Date filed (Month, Day, Year) AUG 0 1 2007 May, Suite 204 Millersville Ms 21108

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20<u>07</u> **Physician** 29 **Ballard** Barbara Ann July 6:03 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2X F Hours Min. Director 59 422-62-8487 18 1947 Alabama Usual Residence of Decedent death with the Maryland 10c. City, Town or Location show 10a, State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notifiled at Director 1 Yes 2 No Md Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17211 Usher Place 20772 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married 2 **⋈** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black 9 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs Comm. Rep. Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert McGill Georgia Mae Washington ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul W. Ballard/Husband 17211 Usher Place Upper Marlboro, Maryland 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 1 Burial 2 □ Cremation 3 □Removal from State 4 Donation 5 Dother (Specify) Lincoln Cemetery 8/4/2007 Suitland, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the diseas shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions Due to for as a nonsequence of: Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed burial-transit Due to (or as a consequence of): ng physician a P.O. Box 68760, Physician/Medical for use IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 X Unknown ğ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 KER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes Certification: To 1 ☐ Inpatient this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of After 1 Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury 1 ☐ Yes 2 ☐ No hours after death. 2 Accident by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in I within 24 hours at Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Condition of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2007

CR (15)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wendell Pierson M.D. 3001 Hospital Drive Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Date filed (Month, Day, Year)

AUG 0 1 2007

|             |   |                     | for<br>State<br>Registrar  | State of Mary  |                        | Certific                                     |                          |  | and Me       | ,                           | Reg. No              | 0.000  | 26351  |
|-------------|---|---------------------|--|--|------------------------|--|--------------------------|--|--------------|-----------------------------|----------------------|--|--|
| 124         | Physicia  | an                  | 1. Decedent's Name (First, Middle, Las   |  |                        |  |                          |  |              | . Date of De<br>Month       | Da                   | ay Year  | 3. Time of Death                                   |
|             | /Medic  | al                  | Bessie 4a. Facility Name (If not institution, give   | J.   |                        |  | Blair<br>ity, Town, or   | Location                               |              | July                        | 30                   | 2007   | 5:37A <sup>M</sup>                                 |
|             | Examin  | er                  | Prince George  |  |                        |  | Cheve                    |  | or Death     |                             |                      | Prince Ge  | orge's   |
| ī           | Funeral   |                     | Social Security Number     6. S  |  | n yrs. last birti      |  | der 1 Year               | if Under<br>Hours                      | 24 Hrs. 8    | . Date of Bir<br>(Month, Da | th                   | 9. Birth   | place (State or Foreign                            |
|             | Director  |                     | 307-10-4093  | □ M 2 1 58   |                        | rs.  | no bayo                  | riours                                 | IVIIII.      | August                      | 30                   | 1948 Arı   | mory, MS   |
|             | land ow   |                     | Usual Residence of Decedent  10a. State 10b. County  | 10   | c. City, Town          | or Location                                  |                          |  |              |                             |                      |  | 10d. Inside City Limits                            |
|             | Mary<br>I-f she<br>fied a   | to                  | Md Prince G  | eorge's  | Ft.                    | . Wash                                       | ingtor                   | ı                                      |              |                             |                      |  | 1 XYes 2 No  |
|             | th the<br>or 28¢<br>e noti  | Jirec               | 10e. Street and Number   |  |                        |  | Zip Code                 |  |              |                             |                      | itizen of What Cou                               | ntry?  |
|             | ath wi  | ral                 | 1009 Colleen Cou   |  |                        |  | 20744                    |  |              |                             |                      | J.S.A.   |  |
| 21215-0036  | be filed within 72 hours after death with the Maryland ital Hygiene. In a train, or items 23a or 28a-f show od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  | 12. Was Decedent Ever<br>Armed Forces?<br>1 ☐ Yes 2 Å No<br>if Yes, Give<br>Year or Dates: | r in U.S.              |  | specify Cuba             | ispanic Ori<br>an, Mexicai<br>Specify: |              | fy Yes or No<br>can, etc.)  | )-                   | 14. Race - Ameri<br>Black, White,<br>Specify: B1 |  |
| <u>ဂ</u>    | 72 ho<br>'natur<br>dical  | Completed           | 15. Decedent's Ed<br>(Specify only highest gra   | ucation<br>de completed)   | 16a.                   | Decedent's U<br>(Give kind of<br>life. DO NO | Jsual Occup<br>work done | ation<br>during mos                    | t of working |                             | 16b. F               | Kind of Business/Ir                              | dustry   |
| 7           | within<br>ene.<br>than '  | dmo                 | Elementary/Secondary (0-12)  | College (1-4or 5+)<br>5+   |                        | <i>⊪</i> e. <i>DO NO</i><br>acher            | Tuse retired             | 0                                      |              |                             | Go                   | overnment  |  |
| ם<br>פ      | al Hygid<br>lother<br>vent, th  | Be Co               | 17. Father's Name (First, Middle, Last)  |  |                        |  |                          | 18. Mothe                              | er's Name (F | First, Middle,              | , Maidei             | n Surname)                                       |  |
| yland       | 2 should be<br>and Mental<br>is marked<br>aumatic ev  | To B                | Henry Braswell   |  |                        |  |                          | Rec                                    | ie Ni        | cho1s                       |                      |  |  |
| Mar         | 2 sho<br>and I<br>is me   |                     | 19a. Informant's Name/Relationship (7  |  | T                      |  |                          |  |              |                             |                      | or Town, State, Zij                              | -  |
| e,<br>e     | 1 and<br>Health<br>em 27<br>ther t  |                     | Willie C. Blair 20a. Method of Disposition   |  |                        |  |                          |  | Ft. V        |                             |                      | n, Marylar<br>ocation - City or T                |  |
| saltimore,  | permit. Pages 1 and 2 should be<br>Department of Health and Menta<br>Important: If item 27 is marked<br>any injury or other traumatic ev<br>once.   |                     | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify   | nemoval nom State  | 20b. Place of cemeters | y, crematory<br>ic Fan                       |                          |  | 8/4/2        | 007                         |                      | ry,Missi   |  |
|             | mit. F<br>partme<br>sortan<br>/ injur   |                     | 21. Signature of Funcial Service Licen   | <u> </u>   | Mason                  |  | and Addres               |  |              |                             |                      | ins Fune   |  |
| Ď           | e a m e e   |                     |  |  |                        | 7474   | Land                     | over                                   | Road         | Landov                      | ær,                  | Maryland   | 20785  |
|             |   |                     | 23a. Part1. Enter the disease, or companies shock, or heart failure. List only   | dications that caused the one cause on each line.  | death. Do n            | ot enter the r                               | node of dyin             | g, such as                             | cardiac or r | espiratory a                | rrest,               |  | Approximate<br>Interval Between<br>Onset and Death |
|             | Physician<br>/Medical   |                     | Immediate Cause (Final disease or condition resulting in death)  | a. Mytustas  |                        |  |                          |  |              |                             |                      |  |  |
|             | Examiner  |                     |  | Breast C   | insequence o           | 1):  |                          |  |              |                             |                      |  |  |
|             | D #   | ner                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a co   | onsequence o           | of):   |                          |  |              |                             |                      |  |  |
|             | ecuted<br>and<br>transi   | Examiner            | Cause (Disease or injury that initiated events resulting in death) Last  | c<br>Due to (or as a co  |                        | n.   |                          |  |              |                             |                      |  |  |
| 00/00       | tificate be executed<br>g physician and<br>as the burial-transit  | al E                | l.   | . Due to (or as a co   | onsequence o           | 11).   |                          |  |              |                             |                      |  |  |
| 00          | ificate<br>g phys   | edical              |  | d  |                        |  |                          |  |              |                             |                      |  | -  |
| O. BOX      | iclan: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit                       | Physician/M         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  | 23c. if yes, outcome pf p<br>1 □ Live birth 2 □<br>4 □ Pregnant at tim<br>9 □ Unknown      | Fetal death            | 3 □Ectopi<br>5 □ Other                       | c pregnancy<br>(specify) |  |              |                             | ;                    | 23d. Date of deliv<br>Month                      | ery<br>Day Year                                    |
| Ţ.          | s that i  | by Ph               | Part II. Other significant conditions of   | ontributing to death but no  | ot resulting in        | the underlying                               | g cause give             | en in Part I                           |              | 23e. Did t                  | tobacco              | use contribute to                                | he cause of death?                                 |
| ecords      | en sig  | ed b                | Renal fails  | e  |                        |  |                          |  |              | 1 🗆                         | Yes 2                | 2 1 Pro  | bably 4 □Unknown                                   |
| i<br>i      | The law rette has be sage 2 sho   | Completed           | Staply loweral   | Sepsis   |                        |  |                          |  |              | 24a. Was                    | psv                  | prior to co                                      | opsy findings available<br>ompletion of cause of   |
|             | tate h  |                     |  |  |                        |  |                          |  |              | perfo<br>1 Yes              | ormed?<br>2 🔀 N      | death?<br>o 1 ☐ Yes                              | 2ĔNo   |
| VII.        | siclan<br>certifi<br>rector   | Be                  | 25. Was case referred to medical examiner?   | Hospital: 17 Inpatient   | 2 ER/Out               | nationt 2                                    | DOA Othe                 | OF:                                    |              | Check only o                |                      | - Fan (a)  |  |
| 5           | g Phys<br>er this<br>eral dir   | n: To               | 27. Manner of Death  | 28a. Date of Injury (Month, Day Ye   | 28b. T                 | ime of                                       | 28c. Injur               | 4 ⊔ N                                  |              |                             |                      | 6 □Other (Speci<br>ury occurred                  | fy)  |
| 2           | ath.<br>or: Aft<br>he fun   | atio                | 1 ■ Natural 5 □ Pending 2 □ Accident investigation   |  | 34/)                   | njury<br>M                                   |                          | Yes 2                                  | No           |                             |                      |  |  |
| DIVISION OF | or Atte   | Certification:      | 3 ☐ Suicide 6 ☐ Could not be determined  | 28e. Place of injury -<br>building, etc. (5  |                        | m, street, fac                               | tory, office             |  | 281          | f. Location (<br>City or To | Street a<br>wn, Stai | and Number or Rur<br>te)                         | al Route Number,                                   |
| ב           | spital<br>ours a<br>neral L   |                     | 29a. Certifier 1 Certifying Ph   | ysician: To the best of m  | v knowledae.           | . death occur                                | red at the tir           | ne. date ai                            | nd place, an | d due to the                | cause(               | s) and manner as                                 | stated.  |
|             | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,  | Medical             | (Check only 2 Medical Exam   | niner: On the basis of exa<br>and manner stated  | amination and          | d/or investiga                               | tion, in my o            | pinion, dea                            | ath occurred | at the time,                | , date ar            | nd place, and due                                | to the cause(s)                                    |
|             | To the To the Comp  | ž                   | 29b. Signature and title of confifier  | Z .  |                        |  | 29c. Licenso             |  |              |                             | -                    | ate signed (Month                                |  |
|             |   |                     |  | upce v.  | M                      |  | 1X                       | 1043                                   | 662          |                             | 1                    | 1430,21  | 007  |
| 0           | (25/  |                     | 30. Name and address of person who will the Buyce  | 100 11   |                        |  |                          | D *                                    | 01           | 1                           | M                    | land 20  | 785  |
|             | Sta   | te                  | 31. Date filed (Month, Day, Year)  | 32. Registrar's  | Signature              | OUL_Hos                                      | spital                   | Driv                                   | re Che       | verly                       | , Mar                | yland 20   | 100  |
|             | Registr   | ar                  | AUG 0 1 2007   | Frank M.   | Ruge                   | 8)   |                          |  |              |                             |                      |  |  |

| State of Manyland / Department of Health and Mantel Heal   | re Legible.  |
|--|--|
| State of Maryland / Department of Health and Mental Hygic<br>1- State Registrar Certificate of Death Reg   |  |
| 1. Decedent's Name (First, Middle, Last)  2. Date of Death 2. Date of Death  | No. 3. Time of Death   |
| Physician Post A Post Control Post Physician Month   | Day Year 31 07 15:25 M   |
| Medical Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death   | 4c. County of Death  |
| Coastal Hospice Salasbury  | Wicomica   |
| Funeral 5. Social Security Number 6. Sek 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days) Hours Min. (Month, Days) Yrs   | 9. Birthplace (State or Foreign Country)                             |
| Director   222-12-8843   TIM 21XF   79   Yrs.     5/7/1928     5/7/1928  | NC   |
|  | 10d. Inside City Limits  |
| Wicomico Salisbury   | 1 ☐ Yes 2€No   |
| MD Wicomico Salisbury  106. Street and Number 106. Zip Code 109  | . Citizen of What Country?   |
| हु है है   900 Rosalie Way 21804   | USA  |
| ## 25 1  | 14. Race - American Indian,<br>Black, White, etc.                    |
| o # io E   LL   1 □ Never Married 2 □ Married   1 □ Yes 2 ∑XNo   1 □ Yes 2 ∑XNo   1 □ Yes 2 ∑X No   1 □ Yes 2 ∑X No   Specify: Year or Dates:  | Specify: White   |
| The state and Number and and Num | b. Kind of Business/Industry   |
| 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  10  Sales  |  |
| Sales Sales  | Printing   |
| D 美工版  | iden Surname)  |
| Daniel B. Green Claudia Davis  19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, C   | 214 T Otata 71- O. (a)   |
| Ronald Bonnaville / son 1805 Mount Hermon Rd., Salisbur  |  |
| 20a. Method of Disposition 20b. Place of Disposition (Name of cemelery, crematory or other place)  | c. Location - City or Town, State                                    |
| 1辺 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)    1切 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)    Bates Cemetery   8/3/07  | Snow Hill, MD  |
|  | Funeral Home   |
| 108 William St., Berlin, MI  | 21811  |
| 23a. Pan . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line.  | Interval Between   |
| Physician disease or condition (Madical resulting in death)  A CARCINOMA OF LUNG  a. CARCINOMA  The substitute of the su | Onset and Death  |
| Physician /Medical Examiner  Medical  Medical  Due to (or as a consequence of):  | A 72 cm . cm   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, [Disease or injury]  | DIOSEASIL  |
| Fary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   Due to (or as a consequence of):  |  |
| petron pure reprise to the resulting in death) Last  The petron pure reprise to the reprise to t |  |
| Due to (or as a consequence of):    Comparison of the control of t |  |
| IF FEMALE: 23c. If yes, outcome pf pregnancy 1   |  |
| IF FEMALE: 23c. If yes, outcome pf pregnancy   1   1   2   3   5   0   0   0   0   0   0   0   0   0   | 23d. Date of delivery  Month Day Year                                |
| 1   Yes 2   No 9   Unknown 9   Unknown   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | cco use contribute to the cause of death?                            |
| to the subsection of the subse | 2 No 3 Probably 4 Unknown  |
| 24a. Was an authors bed a speed a spee | 24b. Were autopsy findings available prior to completion of cause of |
| performed to the position of the property of   |  |
| 25. Was case referred to medical examiner?  1. Types 2000 Hospital: Hospital: Hospital: Description in the control of the cont |  |
| 1 Yes 2 No Hospital: 1 Capatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Resident 27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how  |  |
| 28d. Describe how 28 a. Date of Injury 28b. Time of 28c. Injury at Work?  28d. Describe how 28d. Descr | injury occurred  |
| 3 Suicide 6 Could not be determined 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  | et and Number or Rural Route Number,                                 |
| 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 38b. T | state)   |
| 29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cau Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date   | se(s) and manner as stated.  |
|  | ,                              |
| and manner stated.   | Date signed (Month Day Vesa)   |
| and manner stated.   | Date signed (Month, Day, Year)                                       |
| and manner stated.  29c. License number  29c. License number  29c. License number  30. Name and address of person who completed cause of death (Item 23a) (Type Print)   | Date signed (Month, Day, Year)                                       |
| and manner stated.  29c. License number  29d  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  6 HULAM WARS COASTAL HOSPICE Po Box # 1733 SAL   | Date signed (Month, Day, Year) 7/31/07 1S Rups wo 21802              |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | Date signed (Month, Day, Year) 7/31/07 ISBURY WD 21802               |

|                                |  |                                     | 1 - For<br>State<br>Registrar   |  |  | partment c<br>ertificate   |   |   | ene 2007   | 2335   |
|--------------------------------|--|-------------------------------------|---|--|--|--|---|---|--|--|
| ì                              | Physici<br>/Medic  | al                                  | 1. Decedent's Name (First, Midd<br>David Lee BAI  | KER  |  | 45 City Tow  | A D   | 2. Date of Death<br>Month<br>August   | Day Year 3 2007  | 3. Time of Death 5:20 p M  |
|                                | Examir<br>Funeral<br>Director  | ier                                 | 4a. Facility Name (If not institution  Beverly Healt  5. Social Security Number  218-30-9829  | h Care 6. Sex 7. Age   | (In yrs. last birthda)<br>71 Yrs.  | Hage   | en, or Location of De erstown ear If Under 24 H ays Hours Mi  | rs. 8. Date of Birth  |  |  |
| Baitimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23 is marked other then "netural", or iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be publified at once. | To Be Completed by Funeral Director | 10e. Street and Number  55 E. Washingto  11. Marital Status  1 Never Married 2 Ma  3 Widowed 4 Divorce  15. Decede (Specify only higher Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle  David Edward  19a. Informant's Name/Relation                                    | Ington  On Street #815  12. Was Decedent E Amed Forces? 1   Yes 2   West   1   Yes 3   Yes   1   Yes 2   West   1   Yes 2   West   1   Yes 3   Yes   1   Yes 2   West   1   Yes 3   Yes   2   Yes 3   Yes   3   Removal from State   3   Removal from State | ver in U.S. 13  16a. Dec (Giv life)  Cat  19b. Mai  364  20b. Place of Disp cemetary, or Thagersto | edent's Usual One kind of work do DO NOT use recetaker  ling Address (St. Antieta position (Name o emalory or other wn Crem. C | of Hispanic Origin? Cuban, Mexican, Pur No Specify: Cocupation one during most of waitred)  Of horses  18. Mother's N  Myrt reet and Number or retained by place)  atory   8/6 ddress of Facility | (Specify Yes or No- arto Rican, etc.)  Approximg  The May Bow Rural Route Number, Company  Haverstown Date  20 6/07  Minnich Fu | g. Citizen of What Cou  USA  14. Race - Amen Black, White, Specify:  Sb. Kind of Business/Ir  Race Tra aiden Sumame) | 10d. Inside City Limits  1 X Yes 2 No  ntry?  can Indian, etc.  White dustry  ck  c Code)  0  own, State  Maryland |
| ,00                            | Physician /Medical Examiner the parial-transit the parial-transit  | ical Examiner                       | 23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a c.  | ).   | A  | dying, such as cardi  |   | t,   | Approximate Interval Between Onset and Death 2 Month.  |
| O pox od                       | certific<br>Iding p  | Physician/Med                       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome o<br>1 □ Live birth 2<br>4 □ Pregnant at ti<br>9 □ Unknown  | Fetal death 3  | □Ectopic pregn. □ Other (specif)   |   |   | 23d. Date of deliv<br>Month  | ery<br>Day Year  |
| cords, r                       | equires that<br>en signed b<br>ould be deta  | ٥                                   | Part II. Other significant conditi  | ons contributing to death but  | not resulting in the   | underlying cause   | given in Part I.  |   | cco use contribute to t  | . /  |
| ומו שבכר                       | To the Hospital or Attending Physician: The law requires that the death within 24 hours after death within 25 hours after death. To the Eneral Director: After this certificete hes been signed by the atter completely filled in by the funeral director, page 2 should be detached for use       | e Completed                         | 25. Was case referred to medica   |  |  |  |   |   | prior to co  | opsy findings available impletion of cause of  |
| >                              | s cert   | To B                                | examiner? 1 Yes 2 No  | Hospital:  | t 2 ☐ ER/Outpatie  | at 2 DOA   | 04  | eath (Check only one)   | 0 DOIN (2  | , ,  |
| 5                              | Page 1   |                                     | 27. Manner of Death   |  |  |  |   | 28d. Describe how   | ce 6 Other (Special  | y)   |
| 202                            | Attending<br>death.<br>ctor: Afte<br>y the fune  | Certification;                      | 1 Natural 5 Pendi<br>2 Accident invest<br>3 Suicide 6 Could   | gation   |  | М  | njury at<br>Work?<br>1 Yes 2 No   |   | et and Number or Rura  | al Boute Number  |
| Ś                              | spital or i  |                                     | 4 Homicide determ   | og Physician: To the best of   | y - At home, farm, s<br>(Specify)<br>my knowledge, dea   | th occurred at th  | e time, date and pla  | City or Town,   | State)   | tatad  |
|                                | e Ho<br>24 h<br>e Fui<br>etely   | edlcal                              | (Check only 2 Medical one)  | Examiner: On the basis of e  | ixamination and/or i   | nvestigation, in r   | ny opinion, death oc  | curred at the time, date  | e and place, and due to  | o the cause(s)   |
|                                | within<br>To th<br>comp  | Me                                  | 29b. Signature and title of certifie  | or .   | 1  | 29c. Lid   | ense number   | 290   | 1. Date signed (Month,   | Day, Year)   |
| •                              |  |                                     | Manger  | ( g pro  | 4  |  | 2835  |   | 8-6-07   | D 2/140  |
| 6                              | H-2  |                                     | 30. Name and address of erson   | who completed cause of dea   | tem 23a) (Type   | , Print)   | o chim  | 1-12-0-   | to. M  | 10 ) /7/   |
|                                | Sta  |                                     | 31. Date filed (Month, Day, Year,   | 2 0007 32. Begistrar   | 's Signature   | 8 mil  | 4 61 00   | ruger   | 01000 19   | 0) 0/170   |
|                                | Registr  |                                     | AUG U   | 0 200/   | A. 1   | march 1  |   |   |  |  |

| Physicia   | _            | 1 - State Registrar  1. Decedent's Name (First, Middle, Last)  WALLACE ALLEN BOLDE   | =N   | 2. Date of De.                        | Day   | Year 12:01A  |
|--|--------------|--|--|---------------------------------------|---|--|
| /Medica<br>Examine   |              | 4a. Facility Name (If not institution, give street and number) 701 Cardens Ct.   | 4b. City, Town, or Location of Deal  | h                                     | 4c. Count                                   | y of Death   |
| Funeral<br>Director  |              | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 1 MM 2 F 72 Yrs. Usual Residence of Decedent  |  | 8. Date of Birt<br>(Month, Da         |   | Birthplace (State or Forei Country)  |
| -f show<br>fied at   |              | 10a. State 10b. County 10c. City, Town or to Md. Caroline Federa   |  |                                       |   | 10d. Inside City Lim   |
| a or 28e-f   | Director     | 10e. Street and Number   | 10f. Zip Code  |                                       | 10g. Citizen of                             | What Country?  |
| , or Items 23a or 28e-f show   | by Funeral   |  | 21632  Was Decedent of Hispanic Origin? (5 If Yes, specify Cuban, Mexican, Puer 1 □ Yes 21 No Specify: | Specify Yes or No-<br>to Rican, etc.) | USA<br>14. Ra<br>Bla<br>Specii              | ce - American Indian,<br>ck, White, etc.   |
|  | Completed b  | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)   | edent's Usual Occupation<br>e kind of work done during most of wo<br>DO NOT use retired)               |                                       | 16b. Kind of B                              | Black<br>Business/Industry   |
|  | Be Co        | 9 D:   | river 18. Mother's Nar   | me (First, Middle,                    |   | ea -Plant  |
| nd Mental<br>marked o  | 2 B          | Elmer Benjamin Bolden  | Alice  |                                       |   | annon  |
| Department of Health and Mental Hyg<br>Importent: If Item 27 Is marked othe<br>eny Injury or other treumatic event,<br>QRCs. |              | Glenda Washington/Daug 309  20a. Method of Disposition  1 Natural 2 Cremation 3 Removal from State   | 1 HillCem 07<br>2. Name and Address of Facility Be   | Cambric<br>Date<br>27-07<br>nnie Sn   | dge,Md<br>20c.Location<br>Federa<br>nith Fi | · 21613<br>- City or Town, State<br>alsburg, Md.<br>uneral Home                              |
| sicia<br>bur   | al Exa       | Due to (or as a consequence of):   | LAR CARCINOIS  | NA                                    |   | Onset and Death  |
| ss been signed by the attending phy 2 should be detached for use as the  | nysician/    | 1   Yes 2   No 9   Unknown 9   Unknown   | □Ectopic pregnancy<br>□ Other (specify)  |                                       |   | ate of delivery<br>onth Day Year   |
| een signed   | red by h     | Part II. Other significant conditions contributing to death but not resulting in the to CHRONIC RENAL FAILURE  | underlying cause given in Part I.  |                                       | obacco use conf                             | tribute to the cause of death?   |
| certificate has b<br>rector, page 2 sl   | completed by | 25. Was case referred to medical   |  | 1 ☐ Yes                               | rmed?<br>2 No                               | Were autopsy findings availab<br>prior to completion of cause of<br>death?<br>1 ☐ Yes 2 ☐ No |
| After this funeral di  | 2            | examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie  27. Manner of Death  1 Satural  Accident investigation  3 Suicide 6 Could not be                         | Other: 4 Nursing H  of 28c. Injury at Work?  M 1 Yes 2 No  | ome 5 escribe h                       | dence 6 Oth                                 | red  |
| To the Funeral Direct completely filled in by Madical Certiff  |              | 4 Homicide  determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, deal | th occurred at the time, date and place  | City or Town                          | m, State)                                   | per or Rural Route Number,   |
| within 24 hours after death To the Funerel Director: completely filled in by the Macdical Certificat                         | Medic        | (Check only one)  2 Medicel Examiner: On the basis of examination and/or in and manner stated.  29b. Signature and title of certifier                                | vestigation, in my opinion, death occur 29c. License number DCC630C                                    | rred at the time, d                   | date and place,<br>29d. Date signe          | and due to the cause(s)  d (Month, Day, Year)  25 , 2007                                     |
|  |              |  | 000000   |                                       | 10101                                       | accor  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month JULY 2007 8:02AM M 24 NORA MAY BOZMAN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 806 DOVER ROAD TALBOT EASTON If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 1 F Yrs. 222-05-5306 DELAWARE 85 1922 JAN 6, Director Usual Residence of Decedent the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n with 1 124 CHOPTANK AVE. 21601 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: ral", or items ? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No \$ 3 Widowed 4 □ Divorced Specify: WHITE "naturai", Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than. Elementary/Secondary (0-12) College (1-4or 5+) 8 0 SEAMSTRESS MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked HARRY A. WILSON ည NORA M. WELCH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27 SANDRA H. ERRICKSON/GRANDDAUGHTER 806 DOVER ROAD, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 7/30/2007 EASTON, MARYLAND 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 22. Name and Address of Facility Interval Between Onset and Death Immediate Cause (Final Physician CN disynou/N MOSCHNOTIC 5 400/ resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed inding physician and use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy for Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has page 2 autopsy perform (hronic 2 ☑ No or Attending Physician: ector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify GRANDDAUGHTER ဥ 1 Yes 2 No 2 ER/Outpatient 3□ DOA 27. Mannu Death 28a. Date of Injury 28b. Time of RESIDENCE 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 / Natural 5 ☐ Pending To the nusping within 24 hours after death.

To the Funeral Director: Af 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Luch

P.O. Box 68760.

Division or Vital Records,

State

LUDWIG

30. Name and address, if person who completed cause of death (Item 23a) (Type, Print)

EGLSEDER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 8871 9-7-07 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 7:45 A M 2007 August 9, Marie Gladys Cash /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 2500 Catoctin Ave. Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 579-18-0666 **Funeral** Months Days 1 □ M 2 🗓 F 85 Washington, DC Director Sept.6,1921 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 No Director Frederick Md. Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2500 Catoctin Avenue Unit 2 21702 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 図 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No Saltimore, Maryland 21215-0036 Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Nash Clinton Wells ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar.
Important: If Item 27 Is I
any injury or other trausones. 2500 Catoctin Ave., Unit 2, Frederick, MD. 21702 James Cash/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 11, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4 Donation 5 Dother (Specify) 2007 Suitland, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW., Washington, DC 20007 la. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ongestive Physician /Medical Due to (or as a or nsequence of): **Examiner** iabetes Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician at s the burial-t Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚰 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation To the Hospina.

Vithin 24 hours after death.

To the Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 2007 D005506 1

Registrar

10

State

Aubrie J.

300 West Ninth St., Frederick, Md. 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Nagy, MD.,

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Bepartment of Health and Mental Flygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 9:09 AM FLORENCE LOURENE COOPER 2007 July /Medical 4b. City, Town, or Location of Death 4c. County of Death Name (If not institution, give street and number) Examiner Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 ☐ M 2√2 F 75 218-28-9278 Director 6/14/1932 Maryland Usual Residence of Decedent deeth with the Marylend 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 23a or 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Whiteford Be Completed by Funeral Director MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1511 Deep Run Road 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11. Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🂢 No Specify: Specify: White 3√ Widowed 4 Divorced 'naturel' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be file Deperment of Heelth and Mental Hy Important: If Item 27 is marked oth any linjury or other treumatic event 2008. Mary E. Tomlinson Ray W. Garrett ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Rinaca/Daughter 113 St. Mary's Road, Pylesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Whiteford, MD Mt. Vernon Cemetery 7/6/2007 22. Name and Address of Facility 21. Signature 17314 Harkins Funeral Home, Inc., Delta, PA Ant I what the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Chronis obstruction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires thet the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day ō in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown pege 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 1 ☐ Yes ≥ No 2 ER/Outpatient 3 DOA Medical Certification: To 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Dands 032295 July 2, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BULAKE CIEW, MacPha. DEND 2 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 6 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene

|                                |   |                 | 1- State of Maryland / Registrar   | Department of Health and I<br>Certificate of Death   |  | 7   |  |
|--------------------------------|---|-----------------|--|--|--|---|--|
|                                | 400   | 7               | negistrar  1. Decedent's Name (First, Middle, Last)  | Cortinoate of Beatif   | 2. Date of Death                                   |   | 3. Time of Death                                     |
|                                | Physici<br>/Medic   |                 | Frank Cala   | acino  | July 28,   | 2007 Year                                   | 6:20 P M   |
|                                | Examin  | er              | 4a. Facility Name (If not institution, give street and number)  891 Gallant Fox Lane   | 4b. City, Town, or Location of Death  Davidsonville  | 1  | tc. County of Death                         | 1.01   |
|                                | Funeral   |                 | 5. Social Security Number 6. Sex 7. Age (In vrs. last)   | birthday) If Under 1 Year If Under 24 Hrs.   | 8 Date of Birth                                    | Anne Aruno                                  | alone (Ctata as Fauri                                |
|                                | Director  |                 | 232-28-6235 1 <sup>™</sup> 2□ F 89   | Yrs. Months Days Hours Min.  | March 31,  | 1918 West                                   | trginia  |
|                                | rland<br>ow   |                 | Usual Residence of Decedent  10a. State 10b. County 10c. City, To  | own or Location  |  |   | 10d. Inside City Limits                              |
|                                | a-f sh  | ctor            | Maryland Anne Arundel  | Davidsonville  |  |   | 1 ∐Yes 2 X No  |
|                                | with the  | Director        | 10e. Street and Number   | 10f. Zip Code  | 10g. (   | Citizen of What Cou                         | ntry?  |
|                                | eath v  | Funeral         | 891 Gallant Fox Lane  11. Marital Status 12. Was Decedent Ever in U.S.   | 21035  | acify Vas or No.                                   | USA<br>14. Race - Americ                    | ean Indian   |
| 920                            | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by              | 1 Never Married 2 Married  1 Never Married 2 Married  3 Midowed 4 Divorced  1 Yes, Give Year or Dates:   | <ul> <li>13. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 X No Specify:</li> </ul> | Rican, etc.)                                       | Black, White, Specify: Whi                  | etc.   |
| Baltimore, Maryland 21215-0036 | thin 72 ho<br>le.<br>an "natur<br>Medical   | Completed       | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)   | 6a. Decedent's Usual Occupation<br>(Give kind of work done during most of work<br>life. DO NOT use retired)                  | king 16b.  | Kind of Business/In                         | dustry   |
| 121                            | iled wi<br>Hygier<br>ther th  |                 | 11th  17. Father's Name (First, Middle, Last)  | Jeweler 18 Mothod's North  | ne (First, Middle, Maide                           | Jewelery S                                  | Store  |
| and                            | ld be fi<br>ental H<br>ked ot<br>ic evel  | To Be           | Frank Calacino   |  | ela Renda  | en Surname)                                 |  |
| ary                            | and M<br>s mar  | F               | 19a. Informant's Name/Relationship (Type. Print)   | 9b. Mailing Address (Street and Number or Ru   |  | v or Town, State, Zij                       | Code)  |
| ∑<br>(`                        | and 2<br>lealth<br>m 27 i   |                 |  | 891 Gallant Fox Lane,  |  |   |  |
| nore                           | ages 1<br>nt of H<br>t: If ite<br>/ or ot   |                 | 1 Burial 2 □ Cremation 3 □ Removal from State ceme   | etery, crematory or other place)   |  | Location - City or To                       | •  |
| altin                          | nit. Paratme<br>ortant<br>injury  |                 | 4 Donation 5 Other (Specify) Cedar  21. Signatury 1 Fymeral 5 1 Specify See  | r Hill Cemetery 8-1-<br>22. Name and Address of Facility Ge  |  | itland, MI                                  |  |
| ä                              | permi<br>Depa<br>impo   |                 | 232 Part 1 Enter the disease or complications that caused the death. D   | 2973 Solomons Islan  | nd Rd. Edge  | ewater, MI                                  | 21037  |
|                                | Physician /   |                 | 23a. Part1. Enter the disease, or complications that caused the death. Dishock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Uremia |  | or respiratory arrest,                             |   | Approximate Interval Between Onset and Death I month |
|                                | Examiner  |                 | Due to (or as a consequence Chronic renal  |  |  |   | 2 years  |
|                                | D =   | iner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  |  |  |   | 2 years  |
|                                | xecute<br>and<br>Il-trans   | Examiner        | Cause (Disease or injury that initiated events resulting in death) Last  C   | ee of):  |  |   |  |
| 68760,                         | ificate be executed<br>g physician and<br>as the burial-transit   | edical E        | d  |  |  |   |  |
|                                | ertifica<br>ling ph<br>e as th  |                 | IF FEMALE:   |  |  |   |  |
| P.O. Box                       | w requires that the death certif<br>been signed by the attending<br>should be detached for use a  | Physician/M     | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   |  |  | 23d. Date of delive<br>Month                | ery<br>Day Year                                      |
| No.                            | signed by the   | Completed by Ph | Part II. Other significant conditions contributing to death but not resulting Aortic stenosis  | g in the underlying cause given in Part I.   |  | use contribute to t                         | he cause of death?<br>pably 4  ☐Unknown              |
|                                | The law requires ate has been sign bage 2 should be   |                 | Mitral insufficiency   |  | 24a. Was an  |   | psy findings available                               |
| æ                              | The law<br>cate has<br>page 2 s   | ошо             | Ischemic cardiomyopathy  |  | autopsy<br>performed?<br>↑☐ Yes 2.1 \              | prior to co                                 | mpletion of cause of                                 |
| /ita                           | ician: Th<br>certificate<br>rector, pag   | Bec             | 25. Was case referred to medical examiner?   |  | th (Check only one)                                | 10 100                                      | 2010   |
| or                             | Physician;<br>r this certific<br>ral director,  | ٦.              | 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/C<br>27. Manner of Death 28a. Date of Injury 28b   | · · · · · · · · · · · · · · · · · ·  | ome 5 Residence                                    |   | y)   |
| on                             | Attending i<br>r death.<br>ector: After<br>by the funer   | tion            | 1 X Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation   | D. Time of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No  | 28d. Describe how in                               | ury occurred                                |  |
| Divis                          | f or Attendater death<br>Director:  | Certification:  | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, building, etc. (Specify)  | farm, street, factory, office  | 28f. Location (Street and City or Town, Sta        | and Number or Rura<br>ite)                  | al Route Number,                                     |
|                                | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.  | Medical C       | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.  | ige, death occurred at the time, date and place<br>and/or investigation, in my opinion, death occu                           | , and due to the cause<br>rred at the time, date a | (s) and manner as s<br>and place, and due t | tated.<br>o the cause(s)                             |
|                                | To th<br>within<br>To the<br>compl  | Me              | 29b. Signatife and title of certifier  | 29c. License number  | 29d. D   | ate signed (Month,                          | Day, Year)   |
| )                              | (2)   |                 | Her Samour   | D08314   | J  | uly 30, 2                                   | 007  |
|                                | A. C.   |                 |  | ense Hwy., Annapolis,  | MD 21401   |   |  |
|                                | Sta<br>Registra   |                 | 31. Date filed (Month, Day, Year)  32. Restrar's Signature  AUG 0 1 2007   | K Coasts   |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Mary M. Cummings July 31, 2007 5:30a /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis ElderCare Severna Park Anne Arundel If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 □ M 2 🕅 F Months Days Hours 82 Director 30, 152-12-5276 Nov. 1924 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits te r 28a-f sho notified a MD Anne Arundel Arnold Director 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or items 23a or dical Examiner must be r 487 Louise Lane 21012 Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2X Married 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked otl traumatic ever Be Fred Engroff Pages 1 and 2 should ဥ Viola Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau once. Wanda L. Neice/Daughter 231 Light Street Avenue, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 3, 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 4 □ Donation 5 □ Other (Specify) Crownsville, MD 21. Signature of Funeral Service Ligense Barrancodo Sons, P.A. Severna Park Funeral Ho 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) advance years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and burial-trar Due to (or as a consequence of): Box 68760 attending physician 8 Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 mor Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 s 24a. Was an certificate has autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 2 1 Tyes 1 ☐ Inpatient 2 ER/Outpatient 3 DOA After this 6 ☐Other (Specify) funeral 27. Mann of Death ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t Certification: 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day Year) 1 Natural Injury 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier pletely (Check only one) the ature and title of certif 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year,

AUG 0 1 2007

DHMH 17 Rev 1/2001

eteransthwy Millersville

30. Name and address of person who completed cause of death (Item 23a) (Type,

|                   |   |                  | State of Maryland / Department of Health and Mental Hygiene  |
|-------------------|---|------------------|--|
|                   |   | 100              | The Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death   |
| 3                 | Physic<br>/Medi   |                  | Ernest Gary Christopher July 27 2007 7:00 a  |
|                   | Exami   |                  | 4a. Facility Name (If not institution, give street and number) 413 Light Street  4b. City, Town, or Location of Death Cambridge  4c. County of Death Dorchester  |
| -                 | Funeral   | dis .            | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreit Country)   |
|                   | Director  |                  | 214-58-3708   Tan. 12, 1952 Washington, D  |
|                   | yland<br>how<br>at  |                  | 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limit  |
| 1 1               | ne Mar<br>8a-f s  | ctor             | MD Dorchester Cambridge 1 Drys 2 DN  |
| 2                 | with the Maryland<br>a or 28a-f show<br>the notified at   | Funeral Director | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?   |
| 3                 | death   | eral             | 413 Light Street MD USA  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,   |
| 21215-0036        | after<br>or Ite   | by               | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ★ Never Married 2 ★ Married 3 ★ Widowed 4 ➡ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ★ Never Married 2 ★ Married 5 ★ Married Forces?  1 ★ Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  15. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  16. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  17. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  18. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)   |
| 5-0               | 72 hours<br>"natural",<br>edical Exa  | Completed        | 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working  |
| 121               | within<br>ene.<br>than "<br>he Med  | Į d              | Elementary/Secondary (0-12) College (1-4or 5+)   |
|                   | filed v<br>Hygie<br>other i   | ပ္ပို            | 5 plumber construction  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)   |
| Maryland          | ould be I<br>Mental I<br>narked o   | To Be            | Daniel Ernest Christopher Lillian Ethel Cotton   |
| lary              | 2 should and I is ma  | -                | 19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |
|                   | es 1 and 2 sho<br>of Health and N<br>item 27 is ma<br>r other trauma  |                  | Sharon Taft sister 801 S. Pitt St. #419, Alexandria, VA 22314  |
| nor               | Pages Inent of Hant: If ite   |                  | 20a. Method of Disposition  1 ☐ Burial 2 X Cremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State   |
| Baltimore,        |   |                  | 4 Donation 5 Other (Specify) Salisbury Crematory 7/30/07 Salisbury, MD  21. Signature Funeral Service Picensee 22. Name and Address of Facility Thomas Funeral Home P.A.   |
| B                 | permit. Departr Imports any inj   |                  | 700 Locust St., Cambridge, MD 21613  |
|                   |   |                  | 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between   |
| d                 | Physician   |                  | Immediate Cause (Final disease or condition resulting in death)  a.   The physical and Death VRCVS   |
|                   | /Medical<br>Examiner  |                  | Due to (or as a cons.) nce of):  |
|                   | %≅  | jer              | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |
|                   | scuted<br>nd<br>transit   | Examiner         | Cause (Disease or Injury that initiated events c.  |
| 60,               | cate be executed<br>physician and<br>the burial-transit   | EX               | resulting in death) Last  Due to (or as a consequence of):   |
| 68760,            |   | dical            | d  |
| Box (             | leath certifi<br>attending  <br>I for use as  | n/Me             | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 23d. Date of delivery  |
| P.O. Bc           | The law requires that the death certificate has been signed by the attending agge 2 should be detached for use as           | Physician/Me     | In the past 12 months?  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)  |
|                   | res tha<br>igned<br>be det  | þ                | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?   |
| Oro               | w require<br>been signal  | ed               | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  |
| or Vital Records, | ne law<br>has b<br>ge 2 s   | Completed        | 24a. Was an autopsy 57 and 24b. Were autopsy findings available prior to completion of cause of death?   |
| tal               |   |                  | 1  Yes 2 No 1 Yes 2 No   |
| <u> </u>          | nysic<br>lis ce<br>direc  | To Be            | 26. Place of Death (Check only one)  1 Yes 2D No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (Specify)   |
| n o               |   |                  | 27. Manner of Death 1 Anner of Death 1 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Very at Work?  |
| Division          | ttend<br>death.<br>ctor: /  | Certification:   | 2 Accident investigation M 1 Yes 2 No  |
| <u>≥</u>          | after all Direction by  | ertif            | 4 Homicide  determined  determ |
| _                 | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune. | Medical C        | 29a. Certifier (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |
|                   | To the within 2 To the complex  | Med              | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  |
|                   |   |                  | Vant / (low m) 039749 7/27/07  |
| •                 |   |                  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Oo vice ( Colver word Color Cyn word Party Eastern with 216)   |
|                   | Sta   | te.              | David G Oliver mo 503 Cynwoll Dr. ve Easten mil 2160/ 31. Date filed (Month, Day, Year) 32 Registrar's Signature   |
|                   | Registr   |                  | IIII 3 1 2007  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** Joseph Clark 0513 A M 7 **3**0 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury

If Under 1 Year | If Under 24 Hrs. | Hours | Min. Coastal Hospice A+ The Wicomico 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 128-10-7196 Director 88 9/2/1918 New York Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exa<u>miner must be notified at</u> 1 Yes 2 No Director Maryland Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Winter Quarters Drive 21851 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritai Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 🔀 Married 1 Yes 2 ☐ If Yes, Give Year or Dates: 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ģ 3 Widowed 4 Divorced white Army Completed 16a. Decedent's Usuai Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12 Printing Executive Publishing t of Health and Mental Hygis If item 27 Is marked other or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be William Clark Mary Healy ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Clark/wife 2 Winter Quarters Dr., Pocomoke City, MD 21851 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If it any injury or o once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/31/07 Salisbury, MD Salisbury Crematory 22. Name and Address of Facility Holloway Funeral Home Professional Association 21. Signature of Funeral Service Lige Call 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a conse auence of Examiner the death certificate be executed and resulting in death) Last burial-t Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No ed by the detached 9□Unknown 9 Unknown signed a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral after death.
I Director: After the in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred Division or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Lumber Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3111 10058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVIT HOSPICA THRLAKE POBOX 1737 , SALIS GURY WARG AT 32. Ragistrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

2007

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day Year **Physician** Iola M. Cannon 10:55A M 2007 3, August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Caroline Denton Caroline Nursing Home If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month Day Year) April 7, 1919 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 88 1 M 2 T F Yrs. 212-22-5242 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b, County ral, or items 23a or 28a-f show Examiner must be notified at Caroline 1 ⊋Yes 2 □ No MD Federalsburg Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21632 302 Fairhaven Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black þ 3√ Widowed 4 □ Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Item 27 is marked other than Health Care Nurses Aide 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bessie Evans Willaim Cephas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 401 Porter Court, Federalsburg, MD 21632 William Norman Cephas/ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cokesbury, Maryland 08/11/07 Cokesbury Cemetery 4 □Donation 5 □Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, MD 21632 21. Signature of Funeral Service Licensee Nichael yskow 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Gequentiany fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year detached for 4☐Pregnant at time of death 5 Other (specify) 2 🗆 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ f Yes 2 No 3 Probably 4 Unknown Completed peeu 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA Sitt 28b. Time of 28d. Describe how injury occurred 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After t or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Diractor: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours To the Funeral 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin St Devton Me 21621 31. Date filed (Month AUG) 32 Registrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 26 per dr., g870, 68/21/07dbb Death

Reg. No. 24a per verbal 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** KAREN LESSLEY COLLINS 5 JULY 2007 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DALISBURY NICOMICO PENINSULA (PENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗰 222-30-9827 59 SEPT.1,1947 Director DELAWARE Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director DELAWARE SUSSEX SEAFORD 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 19973 AMERICA 9404 THARP ROAD Funeral Pages 1 and 2 should be filed within 72 hours after death . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married  $_{Specify:}WHITE$ Baltimore, Maryland 21215-0036 "natural", or 1∐Yes 2XXNo Specify: Ď 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. MANUFACTURING TEXTILE WORKER permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If Item 27 is marked other th any Injury or other traumatic event, the once. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEON RALSTON LESSLEY CORA WEST ပ 19bg Addings (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LEWIS L. COLLINS HUSBAND 19973 SEAFORD, DELAWARE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ODDem FEETOWS other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/28/07 SEAFORD, DELAWARE 4 ☐ Donation 5 ☐ Pther (Specify) CEMETERY 21. Signature of Fune Service Licensee WATSON TATES FUNERAL HOME, INC. SEAFORD, DELAWARE 19973 r complications st only one cau hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Approximate Interval Between Onset and Death ck, or hear ailure. Immediate Cause (Final disease or condition resulting in death) **Physician** SYSTEM 026AN FAILURE 140025 /Medical Due to (or as a consequence of) Examiner AUBRIC AND MITHAL VANE IDAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached to 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No s certificate has tirector, page 2 s autopsy perform 1∐ Yes 2 No the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Medical Certification: To 1 npatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi

completely filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) D46111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM TODD, M.D.100 E.CARROLL STREET SALISBURY, MARYLAND 21801

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUL 3 0 2007



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** BETTY DARKIS AUGUST 10 2007 2:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth Feb. 25, Year 1934 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 220-28-4192 1 □ M 2 🛛 F 73 Days Hours Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a, State show 10d, Inside City Limits r 28a-f show notified at Maryland Frederick Frederick 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medic-1 Examiner must be in 1090 Green Wall Place TB21703 U.S.A. s 1 and 2 should be filed within 72 hours after death v if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify:White Specify. þ 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodian Professional Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Hugh Wills, Sr. Lula Ella Adams ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
er 1090 Green Wall Place TB, Frederick, MD 21703 19a. Informant's Name/Relationship (*Type. Print*) 19b. Miss Brenda A. Hamilton, daughter permit. Pages 1 a
Department of Hei
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Aug. 13, 2007 Frederick, Maryland 4 □ Denation 5 □ Other (Specify) Si na ule of Funeral Service Licensee <sup>22</sup> Keeney and Address of Basford PA Funeral Home way CEMOD021 106 East Church St., Frederick, MD 23a. Part1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a consequence of) Examiner COP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to (or as a consequence of Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy perform 1 ☐ Yes 2 ☐ No ospital or Attending Physician: hours after death. 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 □ Accident 5 Pending investigation within 24 hours arter co...

To the Funeral Director: Aft

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20065 443 Lak uaa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elena Iarikova, M.D., 400 West Seventh Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) 3 Registrar's Signature State AUG 1 6 2007 Registrar

7. Age (In yrs. last birthday)

1. Decedent's Name (First Middle Last)

5. Social Security Number

Lauretta Teresa Davis

St. Mary's Hospital

4a. Facility Name (If not institution, give street and number)

6 Sex

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Leonardtown

Reg. No.

2007

St. Mary's

4c. County of Death

3. Time of Death

12:10 P M

9. Birthplace (State or Foreign

2. Date of Death

AUGUST

**Physician** 

/Medical

Examiner

DAVIS

Days Months 1 M 2 M F Hours 220-34-4071 Yrs Director Canada October 8, 1929 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director Maryland St. Mary's Hollywood 1 □Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or items 23a or dival Examiner must be r 43335 Lee Lo Lane 20636 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government ID Badge Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( Joseph Rosmus Pages 1 and 2 should then tof Health and Men Mary Rayter traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau Jeffrey Alan Davis / Son 41045 Paw Paw Hollow Lane Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State August 9 St. John's Cemetery Hollywood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 20Ó7 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A. ardiner P.O. Box 270 Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Plenna /Medical Due to (or as a consequence of): Examiner nemmona Sequentially list conditions, it any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Aturia burial-tran Due to (or as a consequence of): Box 68760 attending physician death certificate be Physician/Medical the. as for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death
9□Unknown Month Day Year 5 Other (specify) P.0. the a 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, \$ Drabello 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 certificate has autopsy performed? Yes 22 No 1∐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient Division or 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D60888 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kakhi M.D.

Begistrar's Signature Box 640 Leonardtown. Krishnan 31. Date filed (Month, Day, Year) State AUG 0 7 2001 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) AUG 0 1 2007

Chandyella

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRNDRASEKHAR KORAPATI... 32. Registrar's Signature

M.D

MD 52855

07-14-07

7207 HANOYER PKWY. # B GREENBELT. M.D. 20770

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Daniel ugust John Elmlinger 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Washington Hagerstown Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min Director 272-46-6895 60 Jan. 11, 1947 Ohio Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10c, City, Town or Location 10b. County 10d. Inside City Limits Director 1 X Yes 2 □ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with I nent of Health and Mental Hygiene. Intit If them 27 is marked other than "natural", or items 23a or 1 and 1 the Medical Examiner must be n. Iny or other traumatic event, the Medical Examiner must be n. 1125 Fairview Road 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: γ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Merchant Services 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P Andrew Elmlinger, Jr. Elizabeth (Mullins) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta S. Elmlinger/Wife 1125 Fairview Road, Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If Its any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) 8/11/2007 Rest Haven Cemetery Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel SMuck 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician odackil 10 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Sue to (or as a consequence of): Examiner requires that the death certificate be executed as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | J⊌nknown The law 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate 1□ Yes 2 **□** N6 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation Injury 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Pay, Year) 2060796 0 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 3 ALLID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

| Russell Clinton F  |               | I - For State  | St  | ate of                              | Maryla   |  | partmer<br><i>Certificat</i>   |                  |                |                         | Mer               | ıtal Hy                    | giene                        | Reg.                                  | No.                 | 20                  |                     | 2636  |
|--|---------------|--|---|-------------------------------------|--|--|--------------------------------|------------------|----------------|-------------------------|-------------------|----------------------------|------------------------------|---------------------------------------|---------------------|---------------------|---------------------|---|
| Physicia<br>Medical Examir   | n/            | Registrar 1. Decedent's Name Russel  |   |                                     | Fraze  | e                                      |                                | -                |                |                         |                   | 1                          | 2. Date of<br>Month<br>Augus | Death                                 |                     | Year                |                     | Time of Death<br>0945 hrs                         |
| ( )  |               | 4a. Facility Name (if 702 Morris A   |   | n, give str                         | eet and nur                                    | mber)                                  |                                | 4                |                | Town, or I              | Location          | of Death                   | Ľ,                           |                                       | 4c. Cou<br>Garre    | inty of De          | eath                |   |
| Funeral<br>Director  |               | 5. Social Security Nu 217-76-93  |   | 6. Sex                              | 2F   | 7. Age (In yr                          | rs. last birthd                | ay)<br>Yrs.      | If Und         | er 1 Year               | _                 | er 24Hrs.                  | 1                            | `                                     | MM/DD/Y             | 1Fc                 | preign              | ce (State or<br>Maryland                          |
| any  | Ì             | Usual Residence of I<br>10a. State 1   | Decedent<br>0b. County  |                                     |  |  | City, Town or                  |                  |                |                         | J                 |                            |                              |                                       |                     |                     |                     | d. Inside City Limits                             |
| rland<br>-f show   | 호             | MD   | Garre   | ett                                 |  | Fr                                     | ciends                         | vil              | 1e<br>10f. Zip | Code                    |                   |                            | Ш                            | 140-                                  | . Citizen o         | f Mhat (            |                     | Yes 2 No  |
| th the Mary 23a or 28a- notified at  | Director      | 702 Morr:  |   | nue,                                | Apt  | 205                                    |                                |                  | 101. 21        | 215                     | 31                |                            |                              | 109                                   |                     | SA                  | Country             |   |
| r death with   | Funeral       | 11. Marital Status 1 Never Married 3 Widowed   | 2 M   | arried 1                            |  | edent Ever in proces?                  |                                | If Y             | es, speci      | ent of His<br>fy Cuban  | panic Or          | igin? ( Spe<br>n, Puerto F |                              |                                       | 14. F               | Race - A            | tc.                 | Indian, Black,                                    |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Melical Examiner   | eted by       | 15. Decedent's Edu   | ıcation (Spe  | cify only h                         | Dates:   | ie completed                           |                                |                  | t's Usual      | Occupat                 |                   | kind of wo                 |                              | 1                                     | 6b. Kind o          | of Busine           |                     |   |
| 5-0036<br>iled within 7<br>Hygiene.<br>I other than<br>the Me lica   | Comple        | 12   |   | 1                                   |  |  | Roo                            | fer              |                |                         | 10 Moths          | er's Name                  | /Eirot Mid                   |                                       |                     |                     | Cor                 | struction   |
| 215-<br>e filed<br>tal Hyg<br>ked oth  | Be C          | 17. Father's Name (F   |   |                                     | ee   |  |                                |                  |                |                         |                   | en Pa                      |                              |                                       |                     | ane)                |                     |   |
| 2121<br>hould be find Mental is marked<br>tric event,  | 리             | 19a. Informant's Nan   |   |                                     |  |  | 4.4                            |                  |                |                         |                   | mber or Ri                 |                              |                                       |                     |                     |                     | Code)   |
| md 2 sho ealth and 2 is reaumati   | -             | Wayne Sar<br>20a, Method of Disp   |   | nder                                | son/s  |  | 0b. Place of I                 |                  |                |                         |                   | Br:                        | ightc<br>Date                |                                       | CO<br>20c. Loca     | 806<br>tion - Cit   |                     | m, State  |
| AOFE ages 1 and of H   |               | 1 Burial 2   | •   |                                     | Removal fro                                    |  | crematory<br>Countr            |                  |                |                         | . 7               | lug 8                      | . 200                        | 17                                    | Davi                | Aevri               | 116                 | . Ра  |
| Baltimore, permit. Pages I am Department of Hea Important: If ite injury or other tr   |               | Donation 5  21. Signature of Fun   | eral Service  | Licensee                            |  |  | Journey                        | 22. N            | lame and       | Address                 | of Facili         | y New                      | wman                         | Fun                                   | eral                | Hom                 | es,                 | P.A.  |
| Physician<br>/Medical<br>Examiner  | miner         | 23a. Part I. Enter the failure. bist only Immediate Cause (For condition resulting Sequentially list con if any, leading to immediate. Enter Under | e disease, or<br>one cause<br>final disease<br>g in death)<br>ditions,<br>mediate | complicate on each I a a. At Due b. | tions that ca<br>ine.<br>herosc<br>to (or as a |  | cardio                         | enter th         | ne mode        | of dying,               | such as           | cardiac or                 | respirato                    | ry arres                              | t, shock, o         | or heart            | A                   | pproximate Interval<br>Between Onset and<br>Death |
| executed<br>an and<br>al - transit   | Exa           | (Disease or injury the events resulting in d   | at initiated  | C                                   | to (or as a                                    | consequen                              | ce of):                        | -                |                |                         |                   |                            |                              |                                       |                     |                     |                     |   |
| E. Si. Se  | dical         | X UNPENDED   |   | A                                   | MENDED.  | 7,perME                                | E,g870,                        | 8/17             | 7/07 5         | T                       |                   |                            |                              |                                       |                     |                     |                     |   |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b | Physician/Me  | IF FEMALE:<br>23b. Was decedent p<br>past 12 months?<br>1 Yes 2 N  |   | he 2                                | 23c. If yes, o                                 | outcome of pointh<br>nant at time o    | oregnancy<br>2                 | Fe               | tal death      | 3                       | Ectop             | oic pregnar                | ncy                          |                                       | 23d. Da<br>Mor      | ate of de           | livery<br>Day       | Year  |
| P.O.  <br>es that the<br>igned by t  | Ď             | Part II. Other signif  | icant condi   | tions co                            | ntributing to                                  | o death but r                          | not resulting i                | n the u          | ınderlyin      | g cause g               | given in F        | Part I.                    |                              |                                       |                     |                     |                     | cause of death? y 4 Unknown                       |
| of Vital Records, P.O.  ng Physician: The law requires that the there this certificate has been signed by metal director, page 2 should be detach  | Completed     |  |   |                                     |  |  | -                              |                  |                |                         |                   |                            | 1 🗸                          | Was ar<br>autopsy<br>perform<br>Yes 2 | y<br>ned?           | prio<br>dea         | r to com            | sy findings available pletion of cause of         |
| ital<br>sician:<br>s certif<br>irector,  | Be            | 25. Was case referre examiner?   | _   |                                     | oital:   | Inpatient 2                            | ER/Outs                        | natient          | 3              | 26.Place                | of Deat<br>Other  | Nursine                    | only one)<br>g Home          | 5 R                                   | tesidence           | 6 🗸 (               | Other: So           | cene  |
| on of Vit<br>nding Physic<br>th: After this  | tion: To      | 27. Manner of Death<br>1 X Natural   |   | J<br>ding                           | 28a. Date                                      |  | 28b. Tir                       |                  |                | 28c. Inju               | ry at Wo<br>Yes 2 | rk?                        | •                            |                                       | ow injury o         |                     |                     |   |
| Division Spiral or Attendinours after death. neral Director: /   | ertification: | 2 Accident 3 Suicide 4 Homicide  | 6 Cou   | estigation<br>ald not be<br>ermined | 28e. Plac<br>(Specify)                         |  | At home, farr                  | n, stree         | et, factor     | y, office b             | uilding,          | etc.                       |                              | tion (Strown, Sta                     |                     | lumber              | or Rural            | Route Number, City                                |
| Divis To the Hospital or A within 24 hours after To the Funeral Dire   | ledical C     | 29a. Certifier   | Certifying F<br>Medical Exa   | aminer:Or                           | To the bes                                     | of examination                         | wledge, death<br>on and/or inv | occur<br>estigat | red at th      | e time, da<br>y opinion | ate and p         | place, and<br>occurred a   | due to the                   | e cause<br>date ar                    | (s) and mand place, | anner as<br>and due | stated.<br>to the c | ause(s)   |
| <b>●</b>   | Me            | 29b. Signature and   | M   | 1                                   | $\sqrt{I}$                                     | W                                      | Stom 22a)                      |                  | 29             | O.C.                    |                   | er                         |                              |                                       | 29d. Date<br>August |                     |                     | Day, Year)  |
|  | 10            | 30. Name and address Susan Hoga  31. Date filed (Month)  | n MD.   | Assista                             | nt Medic                                       | se of death ( cal Exami egistrar's Sig | ner 111                        | 1 Pen            | n Stre         | et, Balt                | timore,           | MD 212                     | 201                          |                                       |                     |                     |                     |   |
| St<br>Regist   | ate           | 31. Date filed (Month  | G 1 3   | 2007                                | Jan Re   | Osea o                                 | A A                            | lan              | 130            |                         |                   |                            |                              |                                       |                     |                     |                     |   |

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Mary Elizabeth Fleetwood /Medical 2007 August 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Caroline Home for Hospice Denton
If Under 1 Year | If Under 24 Hrs. Caroline Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🔀 F Months Days Hours Director 89 220-32-1574 September 3, Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show a or 28a-f show be notified at 10d. Inside City Limits Director 1 ☐Yes 2 ☐ No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 109 South Sixth Street "natural", or items 23ardical Examiner must Funeral 21629 United States of America 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 72 hours after Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☑ No Specify. Specify: Caucasian 3 ☐ Widowed 4 ☐ Divorced Completed Medicai 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Buyer Retail Clothing Store is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Randall H. Knox 2 Elsie Mae Hatfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dottie F. Williams 27 Daughter 32893 Reeses Landing Road, Cordova, Maryland 21625 Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Denton Cemetery 8/6/2007 Denton, Maryland 22. Name and Address of Facility.
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629 21. Signature of Funeral Service License 000 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alzheimers **Physician** HEATI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death Month Day 5 Other (specify) detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has performed? Be 2 Certification: Director: After

Division or Vital Records, P.O. Box 68760, within 24 hours a To the Funeral I

|                             |  |  |  |                         |           |                                     | 1□ Yes                          | 22 No                  | 1 ☐ Yes              | 2□ No             |
|-----------------------------|--|--|--|-------------------------|-----------|-------------------------------------|---------------------------------|------------------------|----------------------|-------------------|
| 25                          | . Was case refer<br>examiner?          | red to medical                               | 11 - 11  |                         |           | 26. Place of Dea                    | ath (Check only o               | ne)                    |                      |                   |
|                             | 1 Yes                                  | No   | Hospital: 1 ☐ Inpatient 2 ☐                          | ER/Outpatient 3         | DOA       | Other: 4 \(\sum \) Nursing H        | lome 5 ☐ Resid                  | dence                  | 6 Kher (Spec         | ity)hospice       |
| 27                          | Manner of Deat  12 Natural  2 Accident | h 5 □ Pending investigation 6 □ Could not be |  | 28b. Time of Injury     |           | njury at<br>Work?<br>1 ☐ Yes 2 ☐ No | 28d. Describe h                 | now injur              | y occurred           | 1111416           |
| 3 ☐ Suicide<br>4 ☐ Homicide |  | determined                                   | 28e. Place of injury - At h<br>building, etc. (Speci | ome, farm, street, fact | ory, offi | ice                                 | 28f. Location (S<br>City or Tow | Street an<br>vn, State | d Number or Rui<br>) | ral Route Number, |
| 29                          | a. Certifier                           | Certifying Ph                                | ysician: To the best of my kno                       | owledge, death occurre  | ed at th  | e time, date and place              | e, and due to the               | cause(s)               | and manner as        | stated.           |

29b. Signature and t tle of certifier

KORAH

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

912 D MARKET ST DENTON MD 2/629 MOOD

00053815

State Registrar

Medical

31. Date filed (Month, Day, Year)

AUG 0 8 2007

Registrar's Signature

|  |                | For<br>State<br>Registrer  | State of   | Marylan   | -                                | rtment of H<br>tificate of I  |                                | d Mental Hy                                       | giene<br>Reg. No.                 | 100  | 260                               | 7:                  |
|--|----------------|--|--|---|----------------------------------|---|--------------------------------|---|-----------------------------------|--|-----------------------------------|---------------------|
| nysicia  |                | 1. Decedent's Name (First, Middle, La. SARAH H. FOSTER   | st)  |   |                                  |   |                                | 2. Date of Dea<br>Month<br>JULY                   | Day                               | Year<br>2007                                 | 3. Time of 7:55                   |                     |
| Medic<br>xamin   |                | 4a. Facility Name (If not institution, giv. WILLIAM HILL MA  |  | nber)   |                                  | 4b. City, Town, or EAST   |                                | Death   | 4c. County                        | of Death                                     |                                   |                     |
| neral<br>ector   |                | 219-16-2694  | ex<br>□M 2XIF  | 7. Age (In yrs.<br>82   | last birthday)<br>Yrs.           | If Under 1 Year<br>Months Days  |                                | Hrs. 8. Date of Birt<br>Min. (Month, Da<br>AUG 11 | y, Year)                          | Cour   | place (State or<br>ntry)<br>YLAND | r Fo <b>r</b> eigi  |
| nd at  | J.             | Usual Residence of Decedent           10a. State         10b. County           MD         TALBO  |  | 10c. Cit  | y, Town or Lo                    |   |                                | -   | ·                                 | 1  | 10d. Inside Cit                   |                     |
| anctiffi   | Director       | 10e. Street and Number   |  |   |                                  | 10f. Zip Code   |                                |   | 10g. Citizen of                   | What Cour                                    | ntry?                             |                     |
| The Modical Exerting must be notified at   | by Funeral     | 24 LYNBROOK TERR  11. Marital Status  1 Never Married 2 Married  3X Widowed 4 Divorced   | 12. Was Dece<br>Armed For<br>1Yes<br>If Yes, Giv<br>Year or Da | rces?<br>2 <b>X</b> No  | 1                                |   | lispanic Originan, Mexican, F  | 1? (Specify Yes or No<br>Puerto Rican, etc.)      | - 14. Rac<br>Bla<br>Specif        | ck, White,                                   |                                   |                     |
| e Medical  | ompleted       | 15. Decedent's E<br>(Specify only highest gra  | ducation<br>ade completed)  College (1                         | -4or 5+)  | (Give<br>life.                   | tent's Usual Occup<br>kind of work done o<br>DO NOT use retired<br>EMAKER | durina most o                  | f working   | 16b. Kind of B                    | usiness/In                                   | -                                 |                     |
| event,   | To Be Co       | 12 17. Father's Name (First, Middle, Last, CHARLES WALLACE   | 1  |   | HOM                              | EFIARER   |                                | Name (First, Middle,<br>DELMAR HEN                | Maiden Surnar                     |  |                                   |                     |
| omer traumant  | Ε.             | 19a. Informant's Name/Relationship (   |  | TED   |                                  |   |                                | or Rural Route Numbe                              | •                                 |  |                                   |                     |
| or other   |                | JOAN F. SCHNEIDE  20a. Method of Disposition  1 Burial 2X Cremation 3  |  | 20b. F  | Place of Dispo<br>cemetery, crer | sition (Name of<br>natory or other plac                                   | ce)                            | Date  | 20c. Location                     | - City or To                                 | own, State                        |                     |
| injury   |                | * 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Licentary)  | y)   | СНЕ   | 22<br>F                          | Name and Addre  | ss of Facility                 | R 7/31/200<br>BEIN & NEW<br>ST., EAST             | NAM FIIN                          |  |                                   |                     |
| thysicien and inglessing in the burial-transit in the burial transit in the burial trans | dical Examiner | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last | a. Me fam. Due to (  | or as a consector as | luence off:                      | leural<br>ancer   | effe                           | işm   |                                   | 7  | Interval Bett<br>Onset and S      |                     |
| ched for use as the  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  |  | inth 2 ☐ Feta<br>ant at time of c   | I death 3                        | Ectopic pregnancy Other (specify)   | /                              |   | 3                                 | ite of deliv                                 | ,                                 | Year                |
| should be detached   | by             | Part II. Other significant conditions of   | contributing to de   | eath but not res  | sulting in the u                 | nderlying cause giv   | en in Part I.                  | 23e. Did t  | obacco use con<br>Yes 2 No        |  | he cause of d<br>bably 4 □l       |                     |
| page z snot  | Completed      |  |  |   |                                  |   |                                | 24a. Was<br>autoj<br>perfo                        | osy<br>ormed2                     | Were auto<br>prior to co<br>death?<br>1  Yes | opsy findings<br>empletion of c   | availabl<br>ause of |
| director,  | o Be           | 25. Was case referred to medical examiner?   | Hospital:  | npatient 2  | ] ER/Outpatier                   | nt 3□ DOA Oth   | -                              | f Death (Check only of<br>ing Home 5 ☐ Resi       |                                   | ner (Speci                                   | fv)                               |                     |
| e funeral d  | <del> </del>   | 27. Manner of Death  1 Natural 5 Pending  2 Accident investigation   | 28a. Date (Mont  | of Injury<br>th, Day Year)  | 28b. Time o<br>Injury            | 28c. Injur<br>Wor   | 2.30                           | 28d. Describe                                     | how injury occur                  |  | 77                                |                     |
| n ka u ph n  | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined  | 200. Flace   | of Injury - At h<br>ng, etc. <i>(Speci</i>  | ome, farm, str                   | eet, factory, office  |                                | 28f. Location (<br>City or To                     | Street and Num<br>wn, State)      | ber or Run                                   | al Route Num                      | iber,               |
| completely filled in by the  | edical         | 29a. Certifier 1 Certifying Pl<br>(Check only 2 Medical Exa-   | miner: On the ba   | best of my kno<br>asis of examina<br>ner stated.  | owledge, deat<br>ation and/or in | h occurred at the tir<br>vestigation, in my o                             | me, date and<br>opinion, death | place, and due to the occurred at the time,       | cause(s) and m<br>date and place, | anner as s<br>and due t                      | stated.<br>to the cause(s         | (ذ                  |
| dwo  | Me             | 29b. Signature and title of certifier  | 54   | Bul   | >                                | 29c. Licens   | se number                      | D   | 29d. Date sign                    | d (Month)                                    | Day, Year)                        |                     |
| . 0  |                | 1010   |  |   |                                  |   | - //                           |   |                                   | 10   |                                   |                     |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 1 per dr., g870, 08 23/197 dbb of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Foxwell Day 2007 **Physician** Month Elsie Willey 1008 AM Avaust /Medical 4b. City, Town, or Location of Death Examiner 4a. Facility Name (If not institution, give street and number) 4c. County of Death Johns Hopkins Hospital -ity 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2√2√1 Days Hours Min. Director 218–16–5671 Usual Residence of Decedent 83 Maryland May 19, 1924 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Dorchester 1X Yes 2 □ No Director Church Creek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1840 White Haven Road Funeral 21622 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes XXNo If Yes, Give 1 Never Married Married ltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 X o Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk es 1 and 2 should be filed w of Health and Mental Hygie fitem 27 is marked other ti Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Solomon Rastall Willey Edith Insley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis E. Smith Son 111 West Martin Street Snow Hill, MD 21863 permit. Pages 1;
Department of He
Important: If item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Old Trinity Church 8/4/2007 Church Creek, Maryland 22. Name and Address of Facility
Thomas Funeral Home, P.A.
700 Locust Street Cambridge, Maryland 21613 21. Signatur / Funeral Service Licensee 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 24 hours Immediate Cause (Final **Physician** Hemorrhage ntracerebra disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Hypertension Due to (or as a consequence of): Sequentially list conditions, if any, bearing to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached g□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy perform certificate 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 this After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: ital or Attending 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) unfu Bukh RES-000 August 1 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Tennifer Berkeley 600 N. Wolfe St., Baltimore HD 21287

Registrar

State

31. Date filed (Month,

Day, Year)

AUG 0 3 2007

Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Month 3:30 P M August 2007 4b. City, Town, or Location of Death 4c. County of Death Clinton Prince Georges 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min. 67 June 28, 1940 Pennsylvania 10h Count 10c. City, Town or Location 10d. Inside City Limits St. Mary's Mechanicsville 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country?

1. Decedent's Name (First, Middle, Last) **Physician** Caroline Louise Gaillot /Medical 4a. Facility Name (If not institution, give street and number) Examiner Clinton Nursing Home 5. Social Security Number **Funeral** Director 181-32-6854 Usual Residence of Decedent 10a. State show r 28a-f show notified at Maryland Director 10e. Street and Number Item 27 Is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be a 25595 Friendship School Road 20659 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any injury or other traumath. Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ronald Montgomery Pauline Shoup 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alfred John Gaillot / Husband 25595 Friendship School Road Mechanicsville, MD 20659 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State August 11. Charles Memorial Gardens Leonardtown, Maryland 4 Donation 5 Other (Specify) 2007 Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the distance, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARDIO AVENOWARY ARREST disease or condition resulting in death) 35 min vik /Medical Due to (or as a consequence of): Examiner RESPOND WAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): physician Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown Day 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, VENTILATUR ARPENDENT, SIP TRANSFERRY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed S/A INTOA COMBAGE MEM ORANGE (PAST) 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an page 2 autonsy perform ESAS (MALTISS PERKARENT) VEGETATIVE STATIE certificate Vital 21 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 o 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending Investigation 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Ans. In 24 hous. Se Funeral Dus. 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Medical

SIS

9

Men

29c. License number D0065086

08/09/07

Year

STRIEET, NW, SVITE 415 WASHINGTON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GORDON O. RAMSAY 106 IRVING

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)

32. Registrar's Signature

AUG 0 9 2007



DHMH 17 Rev 1/2001

State Registrar

To the within 24 the

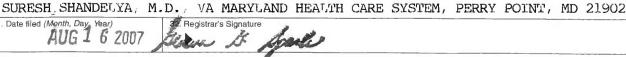
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|                                |  |                     | 1 - Stete<br>Registrer  | State of M  | arylan                            |   | artment<br><i>tificate</i>                          |                           |                                     | nd Me                                   |  | giene<br>Reg. No.                | 11.7                          | . ) ) ] ;                                      |
|--------------------------------|--|---------------------|---|---|-----------------------------------|---|---|---------------------------|-------------------------------------|---|--|----------------------------------|-------------------------------|--|
|                                | Physici  |                     | 1. Decedent's Name (First, Middle, Last) Ann D. Halle   | r   |                                   |   |   |                           |                                     |   | 2. Date of De<br>Month<br>Aug          |                                  | Yeer 2007                     | 3. Time of Death 9:50 PM                       |
|                                | /Medio<br>Examin   |                     | 4a. Fecility Name (If not institution, give s<br>Genesis HealthC  |   |                                   | Pines                                   | 4b. City, T   | Fown, or L                |                                     | Death                                   |  | 4c. Cour                         | ty of Death                   | 1  |
|                                | Funeral<br>Director  |                     | 713.10.3364   | M 250 F 7. Ag   | ge (In yrs. i<br>84               | ast birthday)<br>Yrs.                   | If Under Months                                     | Days                      | If Under 2<br>Hours                 | Min.                                    | 8. Date of Bir<br>(Month, Da<br>Jan. 4 | y, Year)                         | 9. Birth<br>Cou<br>Penr       | place (State or Foreign<br>intry)<br>ISylvania |
|                                | Maryland<br>febow  | tor                 | Usual Residence of Decedent  10a. State  10b. County  Maryland  Dorchest  | ter   | 10c. City                         | , Town or Lo                            | cation<br>mbrids                                    | 70                        |                                     |   |  |                                  |                               | 10d. Inside City Limits                        |
|                                | n with the   | ai Direc            | 10e. Street and Number 5128 North Drive   | LCI   |                                   | Jai                                     | 10f. Zip (  | Code                      | .613                                | *************************************** |  | 10g. Citizen o                   | What Cou<br>USA               | intry?   |
| 920                            | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or items 23s or 28s-f ehow aumstic event, the Musical Examinarity and be multiled at | by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced   | 2. Was Decedent<br>Armed Forces<br>1 Tyes 2 H<br>If Yes, Give<br>Year or Dates: | ?                                 |   | Vas Decede<br>Yes, speci                            | -                         | panic Origi<br>Mexican,<br>Specify: | in? (Spec<br>Puerto P                   | cify Yes or No<br>Rican, etc.)         | - 14. R<br>B                     | ace - Amer<br>lack, White     |  |
| Baltimore, Maryland 21215-0036 | within 72 ho<br>iene.<br>rthen "natur<br>ine Mulical I   | Completed           | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   |   | 5+)                               | 16a. Deced<br>(Give<br>life. L          | lent's Usual<br>kind of work<br>DO NOT use<br>taria | k done dui<br>e retired)  | ring most (                         |   |  | 16b. Kind of                     | Business/I                    |  |
| /land 2                        | uid be filed<br>Mental Hygi<br>irkad other<br>itic evant, II   | To Be C             | 17. Father's Name (First, Middle, Last) Ralph G. Dauer  |   |                                   |   |   |                           | 8. Mother                           | 's Name                                 |  | Maiden Sum                       |                               |  |
| , Mary                         | and 2 sho<br>saith and I<br>n 27 ie ma   |                     | 19a. Informant's Name/Relationship (Typ. John H. Haller/Son   |   |                                   | 11 S                                    | nady I  | Drive                     |                                     |   | dge, M                                 | or, City or Tow<br>D 2161        |                               | p Code)  |
| imore                          | permit. Pages 1 and 2 should be<br>Department of Health and Menta<br>Important: if Item 27 ie marked<br>any Injury or other traumatic ev   |                     | 20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☑ Fig. 4 ☐ Donation 5 ☐ Other (Specify)   |   | Ce                                | lace of Dispo<br>emetery, cren<br>Royal | natory or oth<br>Cemete                             | her place)<br>E <b>rv</b> | ∮8.                                 | .11.                                    | 2007                                   | 20c. Location                    | naw. I                        |  |
| Balt                           | permit.<br>Depart<br>Import<br>any inj   |                     | 21 Jonature of Fundal Service License   | - Am  | we                                | el 3                                    | Name and<br>irran-<br>D8 Hig                        | Address<br>Brom<br>Sh St  | ol Facility<br>Well<br>, Ca         | Fun                                     | eral He                                | me, 216                          | A<br>313                      |  |
| 8760, P                        | Physician<br>/Medical<br>Examiner  |                     | 23a. Párt1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as   | ine.  Crown  a consequ  a consequ | uence of):                              | . /   |                           | . 43                                |   | a Stabe                                |                                  |                               | Approximate Interval Between Onset and Death   |
| O. Box 687                     | death certifi<br>e attending<br>id for use as  | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ø No 9 □ Unknown   | Sc. If yes, outcome 1 Live birth 4 Pregnant a                                   | 2 Fetel                           | death 3                                 | Ectopic pre   |                           |                                     |   |  |                                  | Date of deliver               | rery<br>Day Year                               |
| rds, P.                        | as the   | þ                   | Part II. Other significent conditions conf  | ributing to death b   | out not resu                      | ulting in the ur                        | iderlying ca  | use given                 | in Part I.                          |   | 23e. Did t                             | ,                                |                               | the cause of death?                            |
| Vital Records,                 | The<br>ate h<br>page   | Completed           |   |   |                                   | -                                       |   |                           |                                     |   | 24a. Was<br>autor<br>perfo<br>1 Yes    |                                  | D. Were autoprior to codeath? | opsy findings available ompletion of cause of  |
|                                | Physicien: Th<br>this certificate<br>al director, pag  | To Be               | 1 105 212 140   | ospital:  |                                   | ER/Outpatien                            |   | Other                     | 4 Nurs                              | sing Hom                                |  | dence 6 □C                       |                               | fy)  |
| Division of                    | death.<br>ctor: After<br>the funer   | Certification:      | 27. Manner ol De th  1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  | 28a. Date of Inju<br>(Month, Da   |                                   | 28b. Time of<br>Injury                  | М   |                           | ll<br>s 2 □ N                       | 0                                       |  | now injury occ                   |                               | al Route Number,                               |
| á                              | spital or<br>ours afte<br>serei Dir<br>filled in   |                     | 29a. Certifier 1 Certifying Physi   | building, e   | of my know                        | vledge, death                           | occurred a  | t the time,               | date and                            | place, ar                               | City or Tox                            | vn, State)  cause(s) and i       | manner as                     | stated.  |
|                                | To the Hos<br>within 24 h<br>To the Fun<br>completely  | Medical             | (Check only one) Image: Medical Exeminone)  29b. Signature and title of certifier   | er: On the basis of<br>and manner st  | ol examinat                       | ion and/or inv                          | estigation,   | License n                 | nion, death                         | OCCUITE                                 | d at the time,                         | date and place<br>29d. Date sign | e, and due t                  | to the cause(s)                                |
|                                |  |                     | 30. Name and address of person who  | TIMD pleted cause of c  | death (Item                       | 23а) (Туре.                             | Print),   | De                        | 1.593                               | 3                                       | , , , -                                | , 8                              | 7.7.0                         |  |
|                                | \©   | te                  | MICHAEL ROWL<br>31. Date filed (Month, Day Year)<br>AUG I 6 2007  | 32. Registr   | G [                               | O D                                     | JICHI   | MAN                       | us L                                | ANL                                     | i L                                    | ASTOR                            | y mi                          | 21601  |
|                                | Registr  | ar                  | AUG 1 6 2007  | Marie .   | ميگر د                            | FROM                                    | 10  |                           |                                     |   |  |                                  |                               |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TIPM 24a per VERB (870.8/16/07 WS and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2007 AUGUST William David Hale 6:00 A.M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death VA MARYLAND HEALTH CARE SYSTEM CECIL PERRY POINT 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1√2 M 2 ☐ F 77 **Director** 232-36-7904 1930 West Virginia Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Directo XXYes 2 No Maryland Harford Aberdeen 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 21001 USA 601 N. Paradise Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 □Xes 2 □ No
If Yes, Give
Year or Dates: 1949–52 1 Never Married 2 Married "natural", or 1 ☐ Yes ŽXNo Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 laborer Millwriaht Department of Health and Mental High Important: If item 27 is marked other any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Rebecca Williams Frank Hale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 N. Paradise Rd., Aberdeen, MD 21001 <u>Wanda L.</u> Hale (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ' Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 8/16/07 Aberdeen, Maryland 21. Signature of Funeral Service Licensee Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE UNKNOWN /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2XXVo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide \*\*\*\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52739 AUGUST 11, 2007

 $H_{M}$ 

State Registrar 31. Date filed (Month, Day, Year) AUG 1 6 200



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

|                            |  |                               | For<br>Stete<br>Registrar   | State o  | f Maryland                                      | d / Depa              | artment<br>rtificate         | of H                 | ealth a                     |                 | ental Hyg                       | iene          | 007               | 250                             | 7           |
|----------------------------|--|-------------------------------|---|--|---|-----------------------|------------------------------|----------------------|-----------------------------|-----------------|---------------------------------|---------------|-------------------|---------------------------------|-------------|
|                            |  |                               | Decedent's Name (First, Mide  | dle, Last)   |   |                       |                              |                      |                             |                 | 2. Date of Dea                  |               | Vana              | 3. Time o                       | f Death     |
| п                          | Physicia   |                               | Flicin M  | Partin-  | Aea   | 0                     |                              |                      |                             |                 | Month<br>August                 | Day<br>7      | 2007              | 5:55                            | A. M        |
|                            | /Medic<br>Examin   |                               | 4a. Facility Name (If not instituti   |  | mber)   |                       | 4b. City, T                  | Town, or             | Location o                  | of Death        |                                 | 4c. C         | ounty of Death    | 1                               |             |
| н                          | LAGIIIII   |                               | Mennonite Fel   | lowship Ho   | me  |                       | Hag                          | erst                 | own                         |                 |                                 | Wa            | shingto           | on                              |             |
|                            | Funeral  |                               | 5. Social Security Number   | 6. Sex   | 7. Age (In yrs. la                              |                       | If Under                     | 1 Year<br>Days       | If Under                    | 24 Hrs.<br>Min. | 8. Date of Birth<br>(Month, Day | Year)         | 9. Birth          | place (State                    | or Foreign  |
|                            | Director   |                               | 215-26-8631   | 1 M 2□F  | 85  | Yrs.                  | World                        | Days                 | 110010                      |                 | Oct. 20                         | 192           | 1 Mary            | land_                           |             |
|                            | pu »   | 1                             | Usual Residence of Decedent  10a. State 10b. Count  | h/   | 10c City  | , Town or Lo          | cation                       |                      |                             |                 |                                 |               |                   | 10d. Inside C                   | ity Limits  |
|                            | sho  | ō                             | 10 3. 52  | ington   |   | agerst                |                              |                      |                             |                 |                                 |               |                   |                                 | 2 No        |
|                            | the M  | ect                           | 10e. Street and Number  | IIIgcon  |   | абстве                | 10f. Zip                     | Code                 |                             |                 | 1                               | On Citize     | on of What Co     |                                 |             |
|                            | with e or  | 급                             | 12349 Huyett  | Lane   |   |                       |                              | 740                  |                             |                 |                                 |               | .A.               |                                 |             |
|                            | ns 23  | era                           | 11. Marital Status  | 12. Was Deci   | edent Ever in U.                                | S. 13.                |                              |                      | spanic Orig                 | gin? (Spe       | cify Yes or No-<br>lican, etc.) |               | . Race - Amer     |                                 |             |
| "                          | r Iten   | 핊                             | 1 ☐ Never Married 2 Ma  | Armed For 1 Yes If Yes, Gir                                | rces?<br>2 No                                   |                       |                              | 10                   |                             |                 | Rican, etc.)                    |               | Black, White      | , etc.                          |             |
| 030                        | al', o   | þ                             | 3 ☐ Widowed 4 ☐ Divorce   | ed If Yes, Gir<br>Year or D                                | ve *<br>ates:                                   |                       | 1 ☐ Yes 2                    | No                   | Specify:                    |                 |                                 | 5             | ipecify: W        | hite                            | ١           |
| 21215-0036                 | within 72 hours after death with the Maryland<br>ene.<br>than "natural", or items 23e or 28e-f show<br>the Madical Examiner must be nutified at  | Completed by Funeral Director |   | ent's Education<br>lest grade completed)                   |   | 16a. Dece             | dent's Usua<br>kind of wor   | l Occupa<br>k done d | ition<br><i>uring m</i> osi | t of workin     | ig .                            | 16b. Kind     | d of Business/I   | ndustry                         |             |
| 2                          | ithin se.  | d                             | Elementary/Secondary (0-12)   |  | 1-4or 5+)                                       | life.                 | DO NOT us                    | e retired)           | )                           |                 |                                 | Цоп           | ne Buil           | Jon                             |             |
| 21                         | ygier<br>ygier<br>her th   | S                             | 8   | - ( 1)   |   | Masc                  | )11                          |                      | 10 Motho                    | ela Mama        | (First, Middle,                 |               |                   | der                             |             |
| Ē                          | be fill  | Be                            | 17. Father's Name (First, Middle He   | enry E. Heg  | re.   |                       |                              |                      |                             |                 | Martir                          |               | umame)            |                                 |             |
| Yla                        | ould<br>I Mer<br>narke   | ၉                             |   |  |   | 10h Maili             | Add                          | /Cimata              |                             |                 | Route Number                    |               | Tour State 7      | in Codel                        |             |
| Maryland                   | 12 st<br>h and<br>7 Is n<br>traun  | 9                             | 19a. Informant's Name/Relation Vera Hege/WIf  |  |   | 1                     |                              |                      |                             |                 | stown,                          |               |                   | ip C006)                        |             |
|                            | 1 and<br>Healt<br>em 2   |                               | 20a. Method of Disposition  |  | 20b. P  | lace of Dispo         | sition (Nam                  | ne of                | - 1                         | -               |                                 |               | ation - City or   | Town, State                     |             |
| ō                          | ages<br>nt of<br>t: If it  |                               | 1 ₺ Burial 2 ☐ Cremation  |  | State Men                                       | emetery, crei         | Fell                         | her place<br>.owsh   | ip                          | 8/10            | /07                             | Hage          | rstown            | . Md.                           |             |
| Baltimore,                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Madical Examiner must be nutified at once. |                               | <ul><li>4 □ Donation 5 □ Other</li><li>21. Signature of Funeral Service</li></ul>   |  | Chu   | rch Ce                | Nama and                     | Addrag               | s of Facilit                | h.              |                                 |               |                   |                                 |             |
| Ва                         | Depared Impo   |                               | 1 H Maten   | · Zummer   | wer On  | . Z                   | immerm<br>S. C               | an A<br>arli         | ind Sols                    | ón Fi<br>St. (  | neral E<br>reencas              | dome<br>stle, | Inc.<br>Pa. 1     | 7225                            |             |
|                            |  |                               | 23a. Part1. Enter the disease,<br>shock, or heart failure. Li   | or complications that of                                   | aused the death                                 |                       |                              |                      |                             |                 |                                 |               |                   | Approxima<br>Interval Be        | te<br>tween |
|                            | Physician  |                               | Immediate Cause (Final disease or condition   | (  | anton   | into                  | tinal                        | ) ha                 | alia                        | MGA             | v+ 1                            | Ma            | 10                | Onset and                       | Death       |
|                            | /Medical   |                               | resulting in death)   | a. Due to  | (or as a consequ                                | vence of):            | Triocs                       |                      | (                           | ]               |                                 |               | J -               |                                 |             |
|                            | Examiner   |                               | Sequentially list conditions  | b  |   |                       |                              |                      |                             |                 |                                 |               |                   |                                 |             |
|                            | D ==   | Iner                          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Justo Dusto  | (or as a consequ                                | uence of):            |                              |                      |                             |                 |                                 |               |                   |                                 |             |
| Be                         | and<br>trans   | Examiner                      | that initiated events<br>resulting in death) Last   | c. Due to  | (or as a consequ                                | ience of):            |                              |                      |                             |                 |                                 |               |                   |                                 |             |
| 760,                       | ate be executed<br>nysician and<br>he burial-transit   | calE                          |   | 333.3  | (0. 20 2 0234                                   |                       |                              |                      |                             |                 |                                 |               |                   |                                 |             |
| 687                        | phys<br>the  |                               |   | d  |   |                       |                              |                      |                             |                 |                                 |               |                   | 23                              |             |
| ×                          | certif<br>oding<br>ise as  | /Me                           | IF FEMALE:<br>23b. Was decedent pregnant  |  | tcome of pregna                                 |                       |                              |                      |                             |                 |                                 | 23            | d. Date of deli   | very                            |             |
| Вох                        | atter<br>I for u   | clar                          | in the past 12 months?  |  | ointh 2 ☐ Fetal<br>mant at time of de           |                       | □Ectopic pre<br>□ Other (spe |                      |                             |                 |                                 |               | Month             | Day                             | Year        |
| P.O.                       | the d<br>by the  | ıysi                          | 9 Unknown   | 9□ Unkn  | own   |                       |                              |                      |                             |                 |                                 |               |                   | 10000                           |             |
|                            | The law requires that the death certifica<br>ate has been signed by the attending ph<br>bage 2 should be detached for use as th  | Completed by Physician/Med    | Part II. Other significant condi  | itions contributing to d                                   | eath but not resu                               | ulting in the u       | nderlying ca                 | ause give            | en in Part I                | •               | 23e. Did to                     | bacco us      | e contribute to   | the cause of                    | death?      |
| rds                        | w require<br>been sig<br>should b  | ed t                          | Parkin  | 770M,2 (   | dizea   | DR                    |                              |                      |                             |                 | 1□Y                             | es 2.7        | No 3□Pro          | obably 4                        | ]Unknown    |
| တ္ထ                        | aw re<br>s bee   | plet                          |   |  |   |                       |                              |                      |                             |                 | 24a. Was a                      |               | 24b. Were au      | topsy findings<br>completion of | available   |
| R                          | The I  | Eo                            |   |  |   |                       |                              | _                    |                             |                 | perfor                          |               | death?<br>1 ☐ Yes | _                               |             |
| ita                        |  | Bec                           | 25. Was case referred to medic<br>examiner?   | cal  |   |                       |                              |                      | 26. Place                   | of Death        | (Check only or                  | 18)           |                   |                                 |             |
| <b>→</b>                   | Physicien:<br>r this certific<br>ral director,   | To                            | 1 ☐ Yes 2 No  | Hospital: 1 🗆  | Inpatient 2 🗌                                   | ER/Outpatie           |                              |                      | 4   140                     |                 | ne 5 🗆 Resid                    |               | Other (Spec       | eify) Res                       | Thom        |
| 0                          | fte fte  |                               | 27. Manner of Death<br>1 Natural 5 ☐ Pend   | 28a. Date<br>(Mon  | of Injury<br>th, Day Year)                      | 28b. Time o<br>Injury |                              | 8c. Injury<br>Work   |                             | ,               | 28d. Describe h                 | ow injury     | occurred          |                                 |             |
| sio                        | Attending r death. sctor: After  | catl                          |   | stigation  |   |                       | М                            |                      | Yes 2 🛛                     |                 | 104 Lanation /C                 | *****         | Mumber or Co      | um I Claveta Alve               | mbor        |
| Division of Vital Records, | or At<br>fter d<br>Sirect<br>in by   | ıtil                          |   | minor 200. Place   | of Injury - At ho<br>ing, etc. <i>(Specif</i> ) | ome, tarm, st         | reet, factory                | , office             |                             | 4               | 28f. Location (S<br>City or Tow |               | Number or Hu      | rai Houle ivui                  | TIDOT,      |
|                            | pitel<br>ours a<br>erel (  | Ce                            | 29a. Certifier Certify  | uing Physician: To the                                     | hast of my know                                 | wladaa daat           | h occurred :                 | at the tim           | o date an                   | nd niace a      | and due to the o                | 21/50/5/ 2    | and manner as     | stated                          |             |
|                            | the Hospitel or<br>hin 24 hours afte<br>the Funerel Dir<br>npletely filled in  | Medical Certification:        | (Check only 2 Medic   | ying Physician: To the<br>el Exeminer: On the b<br>and man | asis of examination stated.                     | tion and/or in        | vestigation,                 | in my or             | oinion, dea                 | ath occurre     | ed at the time, o               | late and p    | place, and due    | to the cause                    | (s)         |
|                            | To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu  | Me                            | 29b. Signature and title of certi   | LL-T   |   |                       | 29c                          | . License            | n <i>u</i> mber             |                 | 2                               | 29d. Date     | signed (Month     | n, Day, Year)                   |             |
|                            | - > - 0  |                               | > haluc   | 1/2h   | Doon  |                       | 1                            | (00                  | 63                          | 323             | 3                               | 8/            | 7/0               | 7                               |             |
|                            | h  |                               | 30. Name and address of person  | on who completed cau                                       | se of death (Item                               | 23а) (Туре,           | Print)                       |                      |                             |                 | ^                               |               | -1                | 5                               | 4747        |
|                            | 3  |                               | Shahid M  | ahmoo  | 0 5   | 80                    | NE                           | TYC                  | her                         | 7               | Hve                             | 1             | agen              | stown                           | MD          |
|                            | Sta  |                               | 31. Date filed (Month, Day, Yea   | 6 2007 M   | Registrar's Signa                               | lure                  | and i                        |                      |                             |                 |                                 |               | 0                 |                                 |             |
|                            | Registr  | ar                            | AUG 1   | 6 2007 July  | ares so   | - Same                |                              |                      |                             |                 |                                 |               |                   |                                 |             |

|                            |  |                | For<br>1_ State  | State of Ma  | aryland                     |                                |                          |                   |                   | and M                  |  | _             | 6. 5      | 117                  | 2557   |
|----------------------------|--|----------------|--|--|-----------------------------|--------------------------------|--------------------------|-------------------|-------------------|------------------------|--|---------------|-----------|----------------------|--|
|                            |  |                | Registrar  |  |                             | Ce                             | rtificate                | e OI L            | Jealii            |                        |  | Reg. N        | 0.        |                      | 2 Time of Dooth                                  |
| - 6                        | Physici  | an             | Decedent's Name (First, Middle,  | Last)  |                             |                                |                          |                   |                   |                        | <ol><li>Date of De<br/>Month</li></ol> | Da            |           | Year                 | 3. Time of Death                                 |
|                            | /Medic   |                | Robert Winn  | Hendrix  |                             |                                |                          |                   |                   |                        | August                                 |               |           |                      | 7:20 p.m.  |
| 1                          | Examin   | er             | 4a. Facility Name (If not institution,   | give street and number)                            |                             |                                | 4b. City,                | Town, or          | Location o        | f Death                |  | 40            | c. County | of Death             |  |
|                            |  |                | 14741 MacArthur  |  |                             |                                | Scot:                    |                   | if Under 2        | 24 Uro                 | O Data of Bio                          |               | St. M     | lary's               |  |
| п                          | Funeral  |                |  | 6. Sex 7. Ag<br>1 🗙 M 2 🗆 F                        | ge (In yrs. la              | ist birthday)<br>Y <b>r</b> s. | if Under<br>Months       | Days              | Hours             | Min.                   | 8. Date of Bird<br>(Month, Da          | y, Year       | ")        | Coun                 |  |
|                            | Director   |                | 579-46-7874 Usual Residence of Decedent  |  | 70                          |                                |                          |                   |                   |                        | 12/26/                                 | 193           | 6         | Washi                | ington, DC                                       |
|                            | and<br>w   |                | 10a. State 10b. County   |  | 10c. City,                  | Town or Lo                     | ocation                  |                   |                   |                        |  |               |           | 1                    | 0d. Inside City Limits                           |
|                            | //anyl   | ō              | Maryland St. Ma  | mrr.! o  | Scot                        | land                           |                          |                   |                   |                        |  |               |           |                      | 1 □Yes 2X No                                     |
|                            | the h  | Director       | Maryland St. Ma  10e. Street and Number  | ry s   | SCOL                        | Tanu_                          | 10f. Zip                 | Code              |                   |                        |  | 10g. C        | itizen of | What Cour            | ntry?  |
|                            | with<br>la or<br>t be  |                |  | D  |                             |                                | 2066                     | 2.7               |                   |                        |  | II.           | ليد       | C+-+-                |  |
|                            | ns 2:  | Funeral        | 14741 MacArthur  | 12. Was Decedent                                   | Ever in U.S                 | . 13.                          |                          | lent of Hi        | ispanic Orig      | gin? (Spe              | cify Yes or No                         |               | 14. Rad   | State<br>ce - Americ | an Indian,                                       |
|                            | ter d<br>Iten<br>Iner  | F              | 1 ☐ Never Married 2 💥 Marrie   | Armed Forces?  1 X Yes 2 ☐ If Yes, Give            |                             |                                | If Yes, spec             |                   |                   | i, Puerto I            | Rican, etc.)                           |               | Bla       | ck, White,           | etc.   |
| 336                        | irs al   | by             | 3 ☐ Widowed 4 ☐ Divorced   | If Yes, Give<br>Year or Dates:                     |                             |                                | 1 ☐ Yes 2                | 2 X No            | Specify:          |                        |  |               | Specif    | y: Wh:               | Lte  |
| 21215-0036                 | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or Items 23a or 28a-f show<br>ant, the Medical Examiner must be notified at  | Completed      | 15. Decedent   | s Education  | 7                           | 16a. Dece                      | dent's Usua              | d Occup           | ation             | A of wordsi            |  | 16b.          | Kind of B | usiness/In           | dustry   |
| 715                        | 7, nin 7,<br>In "n<br>Medi   | ple            | (Specify only highes Elementary/Secondary (0-12)   | College (1-4or                                     | 5+)                         | life.                          | kind of wor<br>DO NOT us | se retired        | juring mosi<br>I) | t DI WOIKII            | ng                                     |               |           |                      |  |
| 212                        | filed withir<br>Hygiene.<br>other than<br>ent, the Me  | E              | 11   |  |                             | Mach:                          | inist                    |                   |                   |                        |  | U.S           | . Go      | vernm                | ent  |
| b                          | be filed within 72 hours after death with the Marylan stal Hygiene.<br>ed other than "natural", or Items 23a or 28a-f show<br>event, the Medical Examiner must be notified at                              | Bec            | 17. Father's Name (First, Middle, L  | .ast)  |                             |                                |                          |                   | 18. Mothe         | er's Name              | (First, Middle                         | Maide         | n Surnai  | me)                  |  |
| a                          | ald be<br>fenta<br>rked  | To E           | Cauthen Walter   | Hendrix  |                             |                                |                          |                   | Bett              | у Ва                   | rbara V                                | Vinn          | ı         |                      |  |
| Maryland                   | 12 should be filed w<br>h and Mental Hygie<br>7 <b>is marked other</b> tl<br>traumatic event, th   |                | 19a. Informant's Name/Relationsh   |  |                             | 19b. Maili                     | ng Address               | (Street a         | and Numbe         | er or Rura             | il Route Numb                          | er, City      | or Town   | , State, Zip         | Code)  |
|                            | permit. Pages 1 and 2 should<br>Department of Health and Men<br>Important: If item 27 is marke<br>any Injury or other traumatic.   | ١,             | Charlotte B. He  | ndrix/Wife   |                             | 14741                          | MacA                     | rthu              | ır Dri            | ive.                   | Scotla                                 | nd.           | Mar       | v1and                | 20687  |
| Baltimore,                 | s 1 a<br>f Hea<br>item<br>othe   | 1 1            | 20a. Method of Disposition   |  | l co                        | ace of Disp                    | osition (Nan             | ne of             | - 1               |                        | ate                                    |               |           | - City or To         |  |
| 9                          | Page<br>ent o<br>nt: If  |                | 1 XBurial 2 □ Cremation<br>4 □ Donation 5 □ Other (Sc  |  | ;                           |                                | •                        |                   | · i               | Q/12                   | /2007                                  | Bro           | n trac    | od N                 | Maryland   |
| ≣                          | artm<br>ortar<br>injui   |                | 21. Signature of Funeral Service I   | -  | Tru.                        | 2                              | 2. Name an               | d Addres          | ss of Facilit     | y Bri                  | nefield                                | I En          | nara      | 1 Hor                | ne, P.A.   |
| Ba                         | permit. Pages 'Department of H<br>Important: If ite<br>any Injury or of  | 9 8            | Kyle S. Simon  | s M01206   | - 2                         |                                |                          |                   |                   |                        | d, Leon                                |               |           |                      | 20650  |
|                            | -  |                | 23a. Part1. Enter the disease, or shock, or heart failure. List                                      | complications that cause                           | d the death.                | . Do not en                    | ter the mod              | e of dyin         | g, such as        | cardiac c              | or respiratory a                       | rrest,        | COWL      | 110                  | Approximate<br>Interval Between                  |
|                            |  |                | shock, or heart failure. List of<br>Immediate Cause (Final   | only one cause on each l                           |                             |                                | ( )                      |                   |                   |                        |  |               |           |                      | Onset and Death                                  |
|                            | Physician /Medical   |                | disease or condition resulting in death)   | a. Due to (or as                                   |                             |                                | :11 [                    | ung               | Cav               | 1 cei                  |  | -             |           |                      |  |
|                            | Examiner   |                |  | Due to (or as                                      | a consequ                   | ence or).                      |                          | V                 |                   |                        |  |               |           |                      |  |
| * .                        |  | 100            | Sequentially list conditions,  | b<br>Due to (or as                                 | s a consequ                 | ence of):                      |                          |                   | -                 |                        |  |               |           |                      |  |
|                            | ted<br>nsit  | Examiner       | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events |  |                             |                                |                          |                   |                   |                        |  |               |           | - 1                  |  |
|                            | cate be executed oblysician and the burial-transit   | xar            | that initiated events<br>resulting in death) Last  | c<br>Due to (or as                                 | s a consequ                 | ence of):                      |                          |                   |                   |                        |  |               |           |                      |  |
| 8760,                      | be e<br>ician<br>buris   | <u>富</u>       |  |  |                             |                                |                          |                   |                   |                        |  |               |           |                      |  |
| 87                         | phys<br>the  | dical          |  | d  |                             |                                |                          |                   |                   |                        |  |               |           |                      |  |
| 9 x                        | death certific<br>attending p  | Physician/Me   | IF FEMALE:   | 23c. If yes, outcome                               | e of pregnar                | ncv                            |                          |                   |                   |                        |  |               | 334 D     | ate of deliv         | en/  |
| Box                        | atten<br>for us  | ian            | 23b. Was decedent pregnant in the past 12 months?  | 1 ☐ Live birth                                     | 2 ☐Fetal                    | death 3                        | □Ectopic pr              |                   | /                 |                        |  |               |           | onth                 | Day Year   |
| -                          | the a  | sic            | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 9□Unknown  | at time of de               | atti 3                         | Other (a)                | ecity/_           |                   |                        |  |               |           |                      |  |
| P.0                        | The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit  |                | Part II. Other significant condition   | ns contributing to death t                         | but not resu                | Iting in the                   | underlying c             | ause giv          | en in Part I      |                        | 23e. Did                               | tobacco       | use cor   | ntribute to t        | he cause of death?                               |
| ŝ                          | ires t<br>signe  | δ              | obstructiv   |  | -                           | J                              |                          |                   |                   |                        | 10                                     | Yes           | 2 □ No    | 3 Pro                | bably 4 □Unknown                                 |
| 0                          | requi  | Completed by   |  | pricortis  | . , - ,                     |                                |                          |                   |                   |                        |  |               |           | -                    |  |
| ec                         | law<br>nasb  | Jple.          |  |  |                             |                                |                          |                   |                   |                        | 24a. Was                               | psy           |           | prior to co          | opsy findings available<br>empletion of cause of |
| =                          | The ate h  | 9              |  |  |                             |                                |                          |                   |                   |                        | 1□ Yes                                 | ormed?        |           | death?<br>1 ☐ Yes    | 2 No   |
| /ita                       | Physiclan:<br>r this certifica<br>ral director, I  | Be (           | 25. Was case referred to medical examiner?   |  |                             |                                |                          | 100               |                   |                        | n (Check only                          |               |           |                      |  |
| 7                          | hysic<br>his co  | 2              | 1 ☐ Yes 2 No   | Hospital: 1 ☐ Inpati                               | ient 2 🗆 E                  | ER/Outpatie                    |                          |                   | 4 ⊔ N             | -                      | me 🕉 Res                               |               |           |                      | fy)  |
| 0 _                        | ng Pl<br>fter tl<br>neral  | Ë              | 27. Manner of Death  1 Natural 5 □ Pending   | 28a. Date of Inj<br>(Month, Da                     | ury<br>ay Year)             | 28b. Time Injury               | of 2                     | 28c. Injur<br>Wor | y at<br>k?        |                        | 28d. Describe                          | how in        | jury occu | irred                |  |
| <u>Ö</u>                   | endli<br>ath.<br>or: A   | atic           | 2 Accident investig  | ation  |                             |                                | М                        |                   | Yes 2             | No                     |  |               |           |                      |  |
| Division or Vital Records, | r Attreer de recto   | tific          | 3 Suicide 6 Could n<br>4 Homicide determi  | nod Zoe. Flace Util                                | njury - At horetc. (Specify | me, farm, s                    | treet, factor            | y, office         |                   |                        | 28f. Location (<br>City or To          |               |           | ber or Rur           | al Route Number,                                 |
|                            | talons aftralonal  | Certification: |  |  |                             |                                |                          |                   |                   |                        |  |               |           |                      |  |
|                            | ospi<br>hour<br>uner<br>uner   |                | 29a. Certifier 1 Certifyin (Check only 2 Medical   | g Physician: To the best<br>Examiner: On the basis | t of my knov                | wledge, dea                    | ith occurred             | at the ti         | me, date a        | nd place,<br>ath occur | and due to the                         | cause<br>date | (s) and n | nanner as            | stated.<br>to the cause(s)                       |
|                            | To the Hospital or Attending Physician: The law requir within 24 hours after death. To the Funeral Director: After this certificate has been si completely filed in by the funeral director, page 2 should | Medical        | one)   | and manner s                                       | stated.                     |                                |                          |                   |                   |                        |  |               |           |                      |  |
|                            | To t<br>To t   | ≥              | 29b. Signature and title of certifier  | a. a = H.  | end?                        |                                | 29                       | c. Licens         | e number          | 68                     | 2                                      | 29d. [        | Date sign | ed (Month,           | Day, Year)                                       |
|                            | 11   |                | 1 //m  | In.v. alt  | د٠١٠٠١،                     | 7                              |                          | D.C.              | <b>U</b> ))       | 90                     |  |               | σ         | 171                  | 0  -   |
| ,                          | 10,00  |                | 30. Name and address of person   | who completed cause of                             | death (Item                 | 23a) (Type                     | , Print)                 | 1.1 -             | C 2               | 500                    | 7 10                                   | CYA M.        | 4+        | Ma M                 | 0 7.0650   |
|                            | <i>W</i>   | 1              | Thomas M. W  | ILKINSON, M  | W. L                        | -3146                          | 1 100                    | ikie.             | 721.              | JVIT                   | 1 6                                    | UN1 1/        | -( .0(    | P-11 1 1             | 9 2-200  |

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 1 0 2007

|   | 1                | For<br>State<br>Registrar   | State of                        | of Marylar   |                                   |                       |                             | ealth a<br>D <i>eath</i>           | and M       | ental Hyg<br>R                         | iene<br>g. No.          | . U ) /                       | 2001   |
|---|------------------|---|---------------------------------|--|-----------------------------------|-----------------------|-----------------------------|------------------------------------|-------------|--|-------------------------|-------------------------------|--|
| Physician   |                  | Decedent's Name (First, Middle, Las     Bertie Fay  |                                 | baugh  |                                   |                       |                             |                                    |             | 2. Date of Deat<br>Month<br>August     | Day                     | 07                            | 3. Time of Death 1000 P M                          |
| /Medica<br>Examine  |                  | 4a. Facility Name (If not institution, give   | street and nu                   | ımber)   |                                   | 4b. City              |                             | Location o                         | of Death    |  | _                       | ounty of Death                |  |
|   |                  | Garrett County Me   |                                 |  |                                   | 14 Llast              | Oa<br>or 1 Year             | kland                              |             |  |                         | Garre                         |  |
| Funeral<br>Director   |                  | 5. Social Security Number 6. Se 1   | ex<br>□M 2 <b>X</b> F           | 7. Age (In yrs. 74   | Yrs.                              | Months                |                             | Hours                              | Min         | 8. Date of Birth (Month, Day, Oct. 1,  | Year)                   | Cou                           | nplace (State or Foreigr<br>intry)<br>Yland        |
|   |                  | Usual Residence of Decedent   |                                 |  |                                   |                       |                             |                                    |             |  |                         |                               |  |
| whow  |                  | 10a. State 10b. County  |                                 | 10c. Ci  | ty, Town or Lo                    |                       |                             |                                    |             |  |                         |                               | 10d. Inside City Limits 1 ☐ Yes 2 No               |
| - B   | 900              | MD Garre  | tt                              |  |                                   |                       | nton                        |                                    |             |  | On Citizo               | n of What Co                  |  |
| ben 2   |                  | 10e. Street and Number<br>118 High Crest Dr   | ·ivo                            |  |                                   | 10r. 2                | ip Code                     | 2156                               | 1           | 1                                      | og. Cilizei             | USA                           | unity :  |
| ne 23   | Funeral Director | 11. Marital Status  | 12. Was Dec                     | edent Ever in U  | J.S. 13.                          | Was Dec               | edent of Hi                 | ispanic Orio                       | gin? (Spe   | cify Yes or No-                        | 14.                     | . Race - Amer                 |  |
|   | by Fun           | 1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced   | Armed F                         | orces?<br>2 <b>]</b> No<br>ive   |                                   | If Yes, sp            | ecify Cuba<br>2 <b>∑</b> No | n, Mexican<br>Specify:             | ī, Puerto I | Rican, etc.)                           | S                       | Black, White<br>oecify:       | white  |
| ature   |                  | 15. Decedent's Ed   | lucation                        |  | 16a. Dece                         | dent's Us             | ual Occup                   | ation                              |             |  | 16b. Kind               | of Business/I                 | ndustry  |
| L Mary  | Completed        | (Specify only highest gra   |                                 | )<br>(1-4or 5+)  | (Give                             | DO NOT                | onk done d<br>use retired   | during most<br>()                  | t of workir |  |                         |                               |  |
| -2  | E                | 6   |                                 |  | Pos                               | stal                  | Carr                        |                                    |             |  |                         |                               | Service  |
| ked oth   | To Be (          | 17. Father's Name (First, Middle, Last) Coy Webster   | Erv                             | in   |                                   |                       |                             |                                    | ssie        | (First, Middle, I                      | Maiden Su<br>Lce        | <sup>ımame)</sup><br>Pau      | gh   |
| 7 le mar  | -                | 19a. Informant's Name/Relationship (Claudia G. Shaffe   | •                               | chter  |                                   | •                     |                             |                                    |             | I Route Number<br>Swanton              |                         |                               | ip Code)<br>21561                                  |
| em 2<br>ther  |                  | 20a. Method of Disposition  | .I/ Dau                         | 20b.   | Place of Dispo                    | sition (N             | ame of                      |                                    |             |  |                         | ition - City or               |  |
| Y or o  | 1                | 1 XBurial 2 ☐ Cremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Specific                                 |                                 | 1 State  | cemetery, cre<br>eer Par          |                       |                             | 1                                  | 8/5/        | 07                                     | Dee                     | r Park                        | , Maryland   |
| importan<br>eny injur   | 1                | 21. Signature of Funeral Service  | 0,0                             | De   | 2:                                | 2. Name               | and Addres                  | ss of Facilit<br>neral             | ty          | 32 S                                   | . Sec                   | ond St<br>Maryla              |  |
| 200   | 1                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only                     | plications that<br>one cause on | caused the dea   |                                   |                       |                             |                                    |             |  |                         | 1141 ) 14                     | Approximate<br>Interval Between<br>Onset and Death |
| sician  |                  | Immediate Cause (Final disease or condition resulting in death)                                 | d                               | ronary   |                                   | Dis                   | ease                        |                                    |             |  |                         |                               | Years  |
| edical<br>miner   |                  | Tossining in dodain,  |                                 | o (or as a consection of the c |                                   | Car                   | li our                      | 001112                             | r di        | casca                                  |                         |                               | Years  |
|   | ē                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying              | D                               | (or as a conse   |                                   | Car                   | 11014                       | BCula                              | ı uı        | Всавс                                  |                         |                               | rearb  |
| al-transit  | Examin           | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c                               | (or as a conse   | quence of):                       | _                     |                             |                                    |             |  |                         |                               |  |
| physician and<br>s the burial-transit                           | dical            | (   | d                               |  |                                   |                       |                             |                                    |             |  |                         |                               |  |
| use as  | n/Me             | IF FEMALE:<br>23b. Was decedent pregnant  |                                 | utcome of pregr  |                                   | 76                    |                             |                                    |             |  | 23                      | d. Date of deli               | very   |
| been signed by the attanding I<br>should be detached for use as | Physician/Me     | in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown   |                                 | birth 2 ☐ Fet<br>gnant at time of<br>nown  |                                   | □Ectopic<br>□ Other ( | pregnancy<br>specify)       |                                    | -           | -11200                                 |                         | Month                         | Day Year   |
| deta  | 튑                | Part II. Dther significant conditions of  | ontributing to                  | death but not re   | sulting in the u                  | inderlying            | cause giv                   | en in Part I.                      |             | 23e. Did to                            | bacco use               | contribute to                 | the cause of death?                                |
| n sign  | d by             |   |                                 |  |                                   |                       |                             |                                    |             | 1 🗆 Y                                  | es 2.[X]                | No 3□Pr                       | obably 4 Unknow                                    |
| s bee   | Completed        |   |                                 |  |                                   |                       |                             |                                    |             | 24a. Was a                             |                         | 24b. Were au                  | topsy findings available completion of cause of    |
| aga 2   | E                |   |                                 |  |                                   |                       |                             |                                    |             | autops<br>perfor                       | med?                    | death?                        | 2□ No  |
| certiticate has t   | 0                | 25. Was case referred to medical  |                                 |  |                                   |                       |                             | 26. Place                          | of Death    | (Check only or                         |                         |                               |  |
|   | ToB              | examiner?<br>1 ☐ Yes 2 😿 No   |                                 |  | S ER/Outpatie                     | nt 3 🗆                | Oth Oth                     | er: 4□Nu                           | ursing Ho   | me 5 Resid                             | ence 6                  | □Other (Spe                   | cify)  |
| ctor: After thi   |                  | 27. Manner of Death 1 Manual 5 ☐ Pending  | (Mo                             | of Injury<br>onth, Day Year)   | 28b. Time o<br>Injury             |                       | 28c. Injur<br>Wor           |                                    |             | 28d. Describe h                        | ow injury               | occurred                      |  |
| the f   | Cat              | 2 Accident investigation 3 Suicide 6 Could not b  | e Jac Blad                      | ce of Injury - At I  | home farm st                      | M<br>reet fact        |                             | Yes 2 🗆                            |             | 28f Location (S                        | treet and               | Number or Ru                  | ıral Route Number,                                 |
| d in by   | Certification;   | 4  Homicide determined  | buil                            | ding, etc. (Spec   | ify)                              | rest, race            | ory, ornice                 |                                    |             | City or Tow                            |                         |                               |  |
| 9 ₽   | Medical C        | 29a. Certifier (Check only one)   | niner: On the                   | ne best of my kr<br>basis of examin<br>inner stated.   | nowledge, dea<br>nation and/or in | th occurre            | od at the tir               | me, date <i>a</i> n<br>pinion, dea | nd place, a | and due to the d<br>red at the time, o | ause(s) a<br>late and p | nd manner as<br>lace, and due | stated.<br>to the cause(s)                         |
| To the Fur  | Mec              | 29b. Signature and title of certifier   | and ma                          | anioi sialeu.  | -                                 | 2                     | 9c. Licens                  | e number                           |             | 2                                      | 9d. Date                | signed (Mont                  | h, Day, Year)                                      |
| . 1   |                  | De la   | AR.                             | cken   | h                                 | ny                    | )                           | D6430                              | 2           |  | 81                      | 610                           | 7  |
| 4   |                  | 30. Name and address of person who  | completed ca                    | use of death (It   | n 23a) (Type                      | Print)                |                             |                                    |             |  |                         | ~   /                         |  |
|   |                  | Daniel Buckingham   |                                 |  | Fourt                             |                       | ., Oa                       | kland                              | l, Ma       | ryland                                 | 2155                    | 50                            |  |
| Stat  | e                | 31. Date filed (Month, Day, Year)   | 2007 32.                        | Registrar's Sign   | nature                            | A C                   | 9                           |                                    |             |  |                         |                               |  |

07-05743 Nancy V. Hamilton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 26, 2007 1705 hrs Medical Examiner Nancy Hamilton Virginia 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 2029 E. Belvedere Ave If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** oreign Months Days Hours Country) Maryland Mar 19, 1947 Director 60 215-54-3662 2X F Usual Residence of Deceden 10d, Inside City Limits 10c, City, Town or Location 10b. County 10a, State in Yes 2 No MD Baltimore City 28a-f show "natural", or items 23a or 28a-f shor 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Ö 21239 2029 E. Belvedere Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Yes Specify: White Yes 2 X No specify: Pages I and 2 should be filed within 72 hours after nent of Health and Mental Hygione.
ant: If item 27 is marked other than "natural", o or other traumatic event, the Medical Examiner. If Yes. Give Year 3 X Widowed Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 Insurance Clerical Worker 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Be Thomas Wendel Ogilvie Helen Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) မှ 6N 754 Somerset Drive St. Charles. Hessel Bruce Verhage/nephew 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 08/01/07 Beltsville, MD Chesapeake Crematory Donation 5 Other Specify: ŗ 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21. In ture of Funeral Service Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

April 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart

April 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Between Onset and Physician failure. List only one cause on each line. /Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and tran nvsician/Medical AMENDED g physician a the burial -UNPENDED The law requires that the death certificate be 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year 3 Ectopic pregnancy Month Day 23b. Was decedent pregnant in the Fetal death Live birth 2 past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 V No 9 Unknown the 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Division of Vital Records, P.O. Yes 2 No 3 Probably 4 ✔ Unknown ģ epilepsy Completed 24b. Were autopsy findings available 24a. Was an s been s prior to completion of cause of autopsy performed? death? has No Yes 2 VINO certificate h 26.Place of Death (Check only one) Fo the Hospital or Attending Physician: within 24 hours after death 25. Was case referred to medical Be Residence 6 🗸 Other: Scene Other; examiner? Nursing Home 5 Hospital: 1 FR/Outpatient 3 Inpatient 2 this 1 Yes 2 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After 1 V Natural Yes 2 No Pending Director: Certificati Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide determined (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) Medical 丰 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 30, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD. 32. Restrar's Signature 31. Date filed (Month Alarge T 3 200

State Registrar

ORIGINAL

| 1          | 3   | e.                      | 1. Decedent's Name   | (First, Middle, La        | st)  |                    |                          |                                    |                      |                              | 2                    | Date of De                |                |                           | 3. Time of Death                                     |
|------------|---|-------------------------|--|---------------------------|--|--------------------|--------------------------|------------------------------------|----------------------|------------------------------|----------------------|---------------------------|----------------|---------------------------|--|
|            | Physici<br>/Medic   |                         | Glady  | s Emma                    | a Hyla   | nd                 |                          |                                    |                      |                              | J                    | uly 30                    | ,200°          | 7 Yeai                    | 8:19pm M   |
|            | Examin  |                         | 4a. Facility Name (If  | not institution, giv      | e street and numbe   | r)                 |                          | 4b. City, Tow                      | n, or Loc            | cation of De                 | eath                 | _                         | 4c. C          | County of De              |  |
| 1          |   |                         | Anne Aru   | ndel Med:                 | ical Cent  | er                 |                          | Annap                              | olis                 | ;                            |                      |                           | Anı            | ne Aru                    | ındel  |
|            | Funeral   |                         | 5. Social Security Nu  |                           |  | Age (In yrs. I     | last birthday            | ) If Under 1 You<br>Months Da      |                      | Under 24 H                   | Irs. 8               | Date of Birl              | th<br>v. Year) | 9. B                      | irthplace (State or Foreig                           |
|            | Director  |                         | 070-12-19  | 915 1                     | □ M 2 <b>X</b> F   | 91                 | Yrs.                     | WOTHING                            | iyo I                | TOUTS IV                     |                      | Month, Da<br>Oct. 26      | ,191!          | 5 Pit                     | cairin,NY  |
|            | P. J  |                         | Usual Residence of   |                           |  | 100 City           | , Town or L              | coation                            |                      |                              |                      |                           |                |                           | Taga I all or its                                    |
|            | aryla<br>show<br>dat  | L.                      | 10a. State<br>MD   | 10b. County Prince (      | Toomro! a  |                    |                          |                                    |                      |                              |                      |                           |                |                           | 10d. Inside City Limits 1 💢 es 2 □ No                |
|            | Ba-f  | ctc                     |  |                           | seorge s   | ver                | terir                    |                                    |                      |                              |                      |                           |                |                           |  |
|            | /ith th<br>or 2<br>be no  | <b>Funeral Director</b> | 10e. Street and Num  |                           |  |                    |                          | 10f. Zip Cod                       |                      |                              |                      |                           | 10g. Citize    | en of What (              | Country?   |
|            | ath w   | <u>ra</u>               | 119 Weyr   | mouth Sti                 |  |                    |                          | 207                                |                      |                              |                      |                           | USA            |                           |  |
|            | er de<br>tems   | nue                     | 11. Marital Status   |                           | 12. Was Deceder<br>Armed Forces  | s?                 | S.   13                  | Was Decedent<br>If Yes, specify (  | of Hispa<br>Cuban, N | ınic Origin?<br>∕lexican, Pu | (Specif<br>uerto Ric | y Yes or No<br>can, etc.) | - 1            | 4. Race - An<br>Black, Wh | nerican Indian,<br>nite, etc.                        |
| 20         | s afte  | by F                    | 1 □ Never Marrie<br>3 ☑ Widowed                              |                           | 1 ☐ Yes 20<br>If Yes, Give   |                    |                          | 1 ☐ Yes 2 🗷                        | No S                 | pecify:                      |                      |                           |                | Specify: Wh               | ite  |
| 0000       | 72 hours after death with the Maryland<br>'ratural', or items 23a or 28a-f show<br>dical Examiner must be notified at   |                         |  |                           | Year or Dates  | 5.                 | 16a Dec                  | edent's Usual Oc                   | counation            |                              |                      |                           | 16h Vin        | d of Busines              | a/Industry   |
| ה<br>ה     | "na"<br>edic  | Completed               | (Speci   | 15. Decedent's Ed         | ide completed)   |                    | (Giv                     | e kind of work do<br>DO NOT use re | one durir            | ng most of                   | working              |                           |                |                           | overnment  |
| Ā          | withi<br>ene.<br>than<br>he M   | Ę,                      | Elementary/Secon   | ndary (0-12)              | College (1-4o  | r 5+)              |                          | Libra                              |                      |                              |                      |                           | rede           | erar G                    | Overiment  |
| ν<br>Σ     | filed within<br>Hygiene.<br>Ither than "  | ပ္                      | 17. Father's Name (/   | First, Middle, Last,      |  |                    |                          |                                    |                      |                              | Name (F              | First, Middle,            | Maiden S       | Surname)                  |  |
|            | d be<br>ental<br>ced o  | o Be                    | Martin   | Luther                    |  |                    |                          |                                    |                      | Anna                         | Mar-                 | ia Ma                     | base           | ŕ                         |  |
| 5          | 2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the Me   | 은                       | 19a. Informant's Na  |                           | Type. Print)   |                    | 19h. Mai                 | ing Address (Str                   |                      |                              |                      |                           |                | Town State                | Zin Code)  |
| <u>υ</u>   | nd 2 salth an 27 is r trau  |                         | Laurine H  |                           |  |                    |                          |                                    |                      |                              |                      |                           | -              |                           | , Zip Odde)  |
| ני         | s 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at                        |                         | 20a. Method of Dispo   |                           | Daugnter   | 20b. P             | lace of Disc             | Dominio                            | f                    | ane, c                       | Dat                  |                           |                |                           | or Town, State                                       |
| 2          | ages<br>nt of<br>r: If it   |                         | 1 ⊠ Burial 2 🗆   | ☐Cremation 3 ☐            | Removal from Stat  | le l               |                          | ematory or other                   |                      |                              | gust                 | 9,                        |                | tenha                     |  |
| Dallillion | it. Purtme  |                         | 4 ∐Donation<br>21. Signature of Fur                          | 5 Other (Specif           | **   | MD.                |                          | ans Ceme                           |                      | 2 1                          | 007                  | 1 There                   |                |                           | , P.I.)  |
| Ö          | permit. Pages 1 and<br>Department of Health<br>Important: If item 27<br>any injury or other t   |                         | 21. Signature of tu  | O 3                       |  |                    | '                        | 22. Name and Ad<br>6512 NW         | Cra                  | in Hw                        | beal<br>v F          | LI FUN                    | erai<br>MD 20  | HOME<br>1715              |  |
| ×          |   |                         | 23a Part1 Enter th   | ne disease or dom         | hlications that caus   | ed the death       |                          |                                    |                      |                              |                      | <u>·</u>                  |                | 7713                      | Approximate  |
|            |   |                         | 23a. Part1. Enter th<br>shock, or hear<br>Immediate Cause (F |                           | one cause on each  |                    |                          |                                    |                      |                              |                      |                           |                |                           | Interval Between<br>Onset and Death                  |
| î          | Physician /Medical  |                         | disease or condition resulting in death)                     | 1                         | _a   | + A                | ILUR                     | 2 10                               | 14                   | RIV                          | ٤                    |                           |                |                           |  |
|            | Examiner  |                         | 3  |                           | Due to (or a   | as a consequ       | uence of):               | E TO<br>STA                        | 20.5                 | ~                            | ,                    |                           |                |                           |  |
|            |   | 7                       | Sequentially list con  | nditions,                 | b  | as a consequ       | rence of):               | J 27x                              | 142                  | 7                            | ME                   | NIA                       |                |                           |  |
|            | ted<br>1sit   | Examiner                | Cause. Enter Under<br>Cause (Disease or in                   | lying                     | 240 10 (0. 0   | 20 4 001,004       | 201100 017.              |                                    |                      |                              |                      |                           |                |                           |  |
|            | xecurand and  | xan                     | that initiated events<br>resulting in death) La              |                           | c<br>Due to (or a  | as a consequ       | uence of):               |                                    |                      |                              |                      |                           |                |                           |  |
| 5          | be e<br>sician<br>buria   |                         |  |                           |  |                    |                          |                                    |                      |                              |                      |                           |                |                           |  |
| 000        | eath certificate be executed<br>attending physician and<br>for use as the burial-transit  | an/Medical              |  | _                         | _d   |                    |                          |                                    |                      |                              | -                    |                           |                |                           |  |
| Š          | certif<br>Iding<br>Ise a  | /Me                     | IF FEMALE:   | prognant                  | 23c. If yes, outcom  | ne pf pregna       | incy                     |                                    |                      |                              |                      |                           | 23             | 3d. Date of d             | elivery  |
| Ď          | eath<br>artter<br>for L   |                         | 23b. Was decedent<br>in the past 12 r                        | months?                   | 1□Live birth<br>4□Pregnant   |                    |                          | ☐Ectopic pregna ☐ Other (specifi   |                      |                              |                      |                           | 20             | Month                     | Day Year   |
| į          | the d<br>the d  | Physic                  | 1□Yes 2⊡<br>9□Unknown  | INO                       | 9□Unknown  |                    |                          |                                    | <i>''</i>            |                              |                      |                           |                |                           |  |
| L          | that<br>ed by<br>deta   | / Ph                    | Part II. Other signifi                                       | cant conditions           | ontributing to death   | but not resu       | ulting in the            | underlying cause                   | given ir             | n Part I.                    |                      | 23e. Did to               | obacco us      | e contribute              | to the cause of death?                               |
| 2          | uires<br>sign<br>Id be  | d by                    | 01   | ABGAG                     | S MELL   | 170                | 3                        |                                    |                      |                              |                      | 1 🗆 1                     | Yes 2□         | No 3□                     | Probably 4.4.4 thknow                                |
| COLCE,     | v req<br>beer<br>shou   | ompleted                |  | 1740-                     | 711.2  | 21-1               |                          |                                    |                      |                              |                      | 24a. Was                  | an             | 24h Woro                  | autopov findinge avgilable                           |
| ב<br>ב     | has<br>ge 2   | ш                       |  | 100110                    | 1 HY(CO)   | DISI               |                          |                                    |                      |                              | _                    | autor                     |                | prior to                  | autopsy findings available<br>completion of cause of |
| 7          | n: The  | O                       | OF Was assessed  |                           |  |                    |                          |                                    |                      |                              |                      | 1□ Yes                    | 2.□No          | 1 □ Ye                    | es 2 No  |
| VII.       | sicial<br>certii<br>recto   | Be                      | 25. Was case referrence examiner?                            |                           | Hospital:  |                    | ED/O : "                 |                                    | Other:               |                              |                      | Check only o              |                | _                         |  |
| 5          | Physral di  | : To                    | 1 ☐ Yes 2 ☐ P  | _                         | 1€ Inpa  |                    | ER/Outpatie<br>28b. Time | III 3 DOA                          |                      | 4 ∐ Nursin                   |                      | 5 Resid                   |                | Other (Sp                 | pecify)  |
|            | ding<br>n.<br>After<br>fune   | ion                     | 1 Natural  | 5 ☐ Pending investigation | (Month, L  | Day Year)          | Injury                   |                                    | Injury at<br>Work?   | 2 □ No                       | 200                  | i. Describe i             | now injury     | occurred                  |  |
| 2          | death<br>death<br>ctor:<br>/ the  | ical                    | 2 ☐ Accident<br>3 ☐ Suicide                                  | 6 ☐ Could not be          |  | niury - At ho      | me farm s                |                                    |                      | 2 110                        | 281                  | Location (                | Street and     | Numberor                  | Rural Route Number,                                  |
| UNISION    | or A<br>after<br>Dire   | Certification:          | 4 🗌 Homicide   | determined                | building,  | etc. (Specify      | v)                       | treet, factory, off                |                      |                              | 201                  | City or Tov               | vn, State)     | riamour or i              | rarar Frodic Frambol,                                |
| _          | spital<br>ours<br>eral<br>filled  |                         | 29a, Certifier   | 19 Certifying Ph          | ysician: To the be   | st of mv kno       | wledge, dea              | ith occurred at th                 | ne time.             | date and pl                  | ace, an              | d due to the              | cause(s) a     | and manner                | as stated  |
|            | To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the scompletely filled in by the funeral director, page 2 should be detached it | Medical                 | (Check only one)   | 2 ☐ Medical Exar          | niner: On the basis<br>and manner  | of examina         | tion and/or              | nvestigation, in                   | my opini             | on, death o                  | ccurred              | at the time,              | date and p     | place, and d              | ue to the cause(s)                                   |
|            | orthin<br>comp  | Me                      | 29b. Signature and t   | title of certifier        |  |                    |                          | 29c. Lic                           | ense nu              | mber                         |                      |                           | 29d. Date      | signed (Mo                | nth, Day, Year)                                      |
| )          | ->-0  |                         |  | 1-                        | , ,  |                    |                          | 1                                  | -                    | 567                          | 50                   |                           | 1              | 13010                     | 7  |
| 1          | $\int I(n)$   |                         | 30. Name and addre   | ess of person who         | completed cause of   | ر<br>f death (Item | 23a) (Type               |                                    | 00                   | 367                          | ر ٔ ر                |                           |                | !                         | ,  |
| K          | - (10)  |                         |  |                           | SCHANI   |                    |                          | 18D) CA                            | , 1                  | PKWY                         |                      | ANNE                      | 1001.          | ca                        | 10 214 1   |
|            | Sta   | te                      | 31. Date filed (Monta  | h, Day, Year)             |  | strar's Signa      | ture                     | i wi w                             |                      | rug                          | -                    | ・ハンハン                     | NUL            |                           | -101   |
|            | Regist  |                         | AUG 0 1  | L 2007                    | have 1   | strar's Signa      | ul                       |                                    |                      |                              |                      |                           |                |                           |  |
|            |   |                         | 1104 -   |                           | The same of the sa | -                  | -                        |                                    |                      |                              |                      |                           |                |                           |  |

|                                       |  |                | 1 - For State Registrar   |                   |                       |                                    | nd / Depa                        |                           | t of H                  | ealth a                    |                       | lental F                     | Hygie<br>Reg        | _                | 7                    | 26381  |    |
|---------------------------------------|--|----------------|---|-------------------|-----------------------|------------------------------------|----------------------------------|---------------------------|-------------------------|----------------------------|-----------------------|------------------------------|---------------------|------------------|----------------------|--|----|
|                                       | Physicia   | an             | Decedent's Name (First, Middle,  Market   | Last)             |                       | Uari                               | 222                              |                           |                         |                            |                       | 2. Date of<br>Month          |                     | Day              | Year                 | 3. Time of Death                               | )  |
|                                       | /Medic   |                | Mary  4a. Facility Name (If not institution,  | aive street a     | and num               | Hari<br>ber)                       | spe                              | 4h City                   | Town or                 | Location o                 | of Death              | July                         | 30                  | 4c. County       | of Death             | 4:25   | n  |
|                                       | Examin   | er             | 1105 Schumaker  | -                 |                       | 50.7                               |                                  |                           | lisb                    |                            | , Douit               |                              |                     |                  | omic                 | 0  |    |
|                                       | Funeral<br>Director  |                | 216-34-8103   | 5. Sex<br>1 ☐ M 2 |                       | 92 / Age (In yrs.                  | last birthday)<br>Yrs.           | If Under<br>Months        |                         | If Under I                 | 24 Hrs.<br>Min.       | 8. Date of (Month, 11/8      | Day, Y              | ear)             | 9. Birthp<br>Cour    | place (State or Foreigntry)                    | חן |
|                                       | land   |                | Usual Residence of Decedent  10a. State 10b. County   |                   |                       | 10c. C                             | ity, Town or Lo                  | cation                    |                         |                            |                       |                              |                     |                  | 1                    | 10d. Inside City Limits                        | s  |
| :                                     | death with the Maryland<br>rme 23a or 28a-f ehow   | tor            | Maryland Wicom  | ico               |                       | s                                  | alisbu                           | cv                        |                         |                            |                       |                              |                     |                  |                      | 1 ¥ Yes 2 □ No                                 | o  |
|                                       | or 284   | Directo        | 10e. Street and Number  |                   |                       |                                    |                                  | 10f. Zip                  | Code                    |                            |                       |                              | 10g                 | . Citizen of W   | hat Coul             | ntry?  |    |
|                                       | 23a  | ral            | 1105 Schumaker  |                   |                       |                                    |                                  |                           | 1804                    |                            |                       |                              |                     | USA              |                      |  |    |
|                                       | iter de  | Funeral        | 11. Marital Status 1 ☐ Never Married 2 ☐ Marrie   | Arr               | ned Ford<br>Yes 2     |                                    | J.S. 13.                         | Was Deced<br>If Yes, spec | dent of Hi<br>cify Cuba | ispanic Orig<br>n, Mexican | gin? (Spe<br>, Puerto | ecify Yes or<br>Rican, etc.) | No-                 |                  | - Ameno<br>k, White, | can Indian,<br>etc.                            |    |
| 2-003p                                | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Inportant: if frem 271s marked other than "natural", or Iteme 23a or 28a-f ehow eny injury or other traumatic event, the Maccal Examinar most be notified and once.   | by             | 3 XWidowed 4 ☐ Divorced   | lf Y              | es, Give<br>ar or Da  | )                                  |                                  | 1 🗆 Yes                   | 2 <b>X</b> No           | Specify:                   |                       |                              |                     | Specify.         | wh                   | ite  |    |
| ה<br>ה                                | natur  | Completed      | 15. Decedent's (Specify only highest  |                   | ileted)               |                                    | 16a. Dece                        | dent's Usua<br>kind of wo | al Occupa               | ation<br>during most       | of works              | ng                           | 16                  | b. Kind of Bu    | siness/In            | dustry   |    |
| 7                                     | then the   | Idm            | Elementary/Secondary (0-12)   | Co                | llege (1-             | 4or 5+)                            |                                  | _                         |                         |                            |                       | -                            |                     | Uaal+k           |                      | _  |    |
| 7 5                                   | Hygie<br>Sther<br>ant, II  | ပို            | 17. Father's Name (First, Middle, L.  |                   | ,                     |                                    | Filys.                           | LCai                      | THEL                    | apist<br>18. Mothe         | r's Name              | (First, Mid                  | dle, Ma             | Health           |                      | 3  |    |
| yland                                 | Mental<br>Mental<br>Med c  | To B           | Joseph Reid Mas   | on                |                       |                                    |                                  |                           |                         | Emi                        | ly K                  | night                        |                     |                  |                      |  |    |
| Mary                                  | and N  |                | 19a. Informant's Name/Relationshi   | p (Type, Pri      | nt)                   |                                    | 19b. Maili                       | ng Address                | (Street a               | and Numbe                  | r or Rura             | l Route Nu                   | mber, C             | City or Town,    | State, Zip           | Code)  |    |
|                                       | and sand m 27 m 27 her tra   |                | Barbara L. Care   | y/fri             | end                   |                                    |                                  |                           |                         | hire :                     | Dr.,                  | Sali                         |                     | y, MD            |                      |  |    |
| Dallimore                             | or of  |                | 20a. Method of Disposition<br>1 Durial 2 XCremation   |                   | l from S              |                                    | Place of Dispo<br>cemetery, crei | natory or o               | ne of<br>ther plac      |                            |                       | )ate                         | 20                  | c. Location -    | City or To           | own, State                                     |    |
|                                       | ortant<br>njury  |                | 4 ☐ Donation 5 ☐ Other (Special Service Li  | F7/2              |                       | Sa                                 | lisbury                          | / Cre                     | nato                    |                            | 8/2/                  |                              | _ 5                 | Salisbu          | ry,                  | MD   | _  |
| 0                                     | Depa<br>Impo<br>eny is   |                | > Kouth C   | then              | 200                   | CETT                               | >   1                            | 10110<br>101 S            | way                     | Funer                      | al H                  | ome Pi<br>Sali:              | rofe<br>sbur        | essiona<br>y, MD | 11 As                | ssociation                                     | 1  |
|                                       |  |                | 23a. Part1. Enter the disease, or c<br>shock, or heart failure. List o  | omplications      | that ca               | used the dea                       |                                  |                           |                         |                            |                       |                              |                     |                  |                      | Approximate<br>Interval Between                |    |
| F                                     | hysician   | į II           | Immediate Cause (Final disease or condition   | a                 |                       | ASCI                               | G/                               |                           |                         |                            |                       |                              |                     |                  |                      | Onset and Death                                |    |
|                                       | /Medical<br>Examiner   |                | resulting in death)   | ( "               | ue to (o              | r as a consec                      |                                  |                           |                         |                            |                       |                              |                     |                  |                      |  |    |
|                                       |  | <u>_</u>       | Sequentially list conditions,   | b                 | Due to (o             | r as a consec                      |                                  |                           |                         |                            |                       |                              |                     |                  |                      |  |    |
|                                       | ured<br>d<br>ansit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events | c.                | ·                     |                                    | ,                                |                           |                         |                            |                       |                              |                     |                  |                      |  |    |
| S C                                   | be executed icien and purial-transit   | Exa            | resulting in death) Last  |                   | Due to (o             | ras a consec                       | quence of):                      |                           |                         |                            |                       |                              |                     |                  |                      |  |    |
| -                                     | 9 × 9  | Ilcal          | •   | d.                |                       |                                    | -                                |                           |                         |                            |                       |                              |                     |                  |                      |  |    |
| 00 X                                  | ding p   | Physician/Med  | IF FEMALE:  | 23c If v          | es outo               | e<br>ome of pregn                  | ancy                             |                           | - 27.00                 |                            |                       |                              |                     | T                |                      |  |    |
| בא<br>מ                               | atten<br>I for us  | clan           | 23b. Was decedent pregnant in the past 12 months?   | 1                 | Live bir              | th 2 Feta                          | al death 3                       | Ectopic pr<br>Other (sp   |                         |                            |                       |                              |                     | 23d. Date<br>Mor |                      | ery<br>Day Year                                |    |
| <u>;</u>                              | by the ached   | hysi           | 1  Yes 2  No<br>9  Unknown  | 9[                | Unknov                | wn                                 |                                  |                           | ,,                      |                            |                       |                              |                     | E                |                      |  |    |
| ָה<br>ה                               | gned I   | by P           | Part II. Other significant condition  | s contributir     | ng to dea             | ath but not res                    | sulting in the u                 | nderlying c               | ausa give               | an in Part I.              |                       | 23a. D                       | id toba             | cco use contr    | bute to t            | he cause of death?                             |    |
| ecolus,                               | is uee   |                |   |                   |                       |                                    |                                  |                           |                         |                            |                       | 1                            | ☐ Yes               | 2.00 No          | 3 🗌 Prob             | pably 4 [Unknowl                               | n  |
| בי בי                                 | has by<br>e 2 st   | Completed      |   |                   |                       |                                    |                                  |                           |                         |                            |                       |                              | utopsy              | p                | rior to co           | ppsy findings availabl<br>mpletion of cause of | Θ  |
| 5                                     | icate<br>r. pag  |                |   |                   |                       |                                    |                                  |                           |                         |                            |                       | 1 □ Ye                       | s 20                |                  | eath?                | 2□ No  |    |
| \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | s certil   | To Be          | 25. Was case referred to medical examiner?  1 Yes 2 No  | Hospita           | l: 1 🗆 In             | patient 2                          | ER/Outpatier                     | it 3 DC                   | Othe                    | 200                        |                       | Check on                     |                     | e 6 □Othe        | . /С                 |  |    |
| 5 8                                   | g rm<br>erths<br>neral c   |                | 27. Manner of Death   | 28a               | Date of               |                                    | 28b. Time o                      |                           | 8c. Injury              | at                         |                       |                              |                     | injury occurre   |                      | у)   |    |
|                                       | endin<br>eath.<br>or: Afi<br>he fur  | atlo           | 1 Natural 5 Pending 2 Accident investiga  |                   | (101017111            | , Day 1 Gar)                       | Injury                           | М                         |                         | Yes 2 1                    | No                    |                              |                     |                  |                      |  |    |
|                                       | in by t  | Certification: | 3 Suicide 6 Could no<br>4 Homicide determin   | ed 28e            | . Place o<br>building | of Injury - At h<br>g, etc. (Speci | ome, farm, str<br>fy)            | eet, factory              | , office                |                            |                       |                              | n (Stree<br>Town, S |                  | or Or Rura           | al Route Number,                               |    |
| _                                     | ours a cours a |                | 29a. Certifier 1 Certifying   | Physicien:        | To the h              | est of my kn                       | owledge deat                     | 2 Occurred                | at the tim              | ne date an                 | d place               | and due to t                 | he cau              | ca/e) and may    | anor ac c            | tated  |    |
|                                       | I of the prospital or Artendary Prystolen: The law requires that the death Sertings within 24 hours stafer death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the   | Medical        | (Check only 2 Medical E. one)   | xamıner: Or       | n the bas             | sis of examination stated.         | ation and/or in                  | vestigation               | , in my or              | pinion, deal               | th occurr             | ed at the tin                | ne, date            | and place, a     | nd due to            | o the cause(s)                                 |    |
| 1                                     | within<br>To th  | ž              | 29b. Signature and title of certifier   |                   |                       |                                    |                                  |                           | . License               |                            |                       |                              |                     | . Date signed    |                      |  |    |
|                                       | 0  |                | ) Nh h  | /                 |                       |                                    |                                  |                           | DH                      | 709                        | 4                     |                              |                     | 8/1/0            | 7                    |  |    |
| l                                     | em   |                | 30. Name and address of person w  | 1                 |                       | of death (Ite                      | m 23a) (Type,                    | Print)                    | D14.                    | 6 hl                       | V                     | 511                          | 1,2                 | 8/1/0<br>Bury    | 100                  | ()   |    |
| 100                                   | Sta  | te             | 31. Date filed (Month, Day, Year)<br>AUG 02   | 2007              | 32. P                 | gistrar's Sign                     | ature                            | 7                         | 7 i V .                 | 710                        |                       | JA                           | 1/2                 | JUKY             | , VV                 | 1+   |    |
|                                       | Registr  | ar             | AUG UZ  | 2007              | 100                   | alua.                              | H A                              | souls)                    | ,                       |                            |                       |                              |                     |                  |                      |  |    |

|                            |  |   | 0400  | Type or Print in Black In  |   | -  |   |  |
|----------------------------|--|---|---|--|---|--|---|--|
|                            |  |   | For<br>State<br>Registrar   | State of Maryland / Depa   | artment of Health and I<br>rtificate of Death   |  | ene<br>g. No.C. U 🕠   | 1 2.00   |
|                            | Physici<br>/Medic  |   | Decedent's Name (First, Middle, La     Richard James Hu   | ·  |   | 2. Date of Death<br>Month<br>July 31   | Day Year  | 3. Time of Death  12:05A <sup>M</sup>  |
|                            | Examin   |   | 4a. Facility Name (If not institution, given  | ve street and number)  | 4b. City, Town, or Location of Death  | 1  | 4c. County of De  |  |
|                            |  | 10  | 6721 Woodridge R  |  | New Market  If Under 1 Year   If Under 24 Hrs.  | 10 D : (D::)   | Frederic  |  |
| b                          | Funeral<br>Director  |   | 276-42-3716   | Sex<br>1X M 2 F 7. Age (In yrs. last birthday)<br>60 Yrs.  | Months Days Hours Min.  | 8. Date of Birth (Month, Day, 19)  March 29  |   | irthplace (State or Foreign<br>Country)<br>Dhio  |
|                            | and<br>t   |   | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, Town or Lo  | cation  |  |   | 10d. Inside City Limits  |
|                            | Mary<br>-f sho   | to  | Maryland Frederi  | ck New Mark  | a+  |  |   | 1 □Yes 2XXNo   |
|                            | r 28a  | Director  | 10e. Street and Number  | new Halk   | 10f. Zip Code   | 10   | g. Citizen of What C  | Country?   |
|                            | h witl   | a<br>D  | 6721 Woodridge R  | Road   | 21774   | U  | nited Sta   | ites   |
|                            | deat   | Funeral   | 11. Marital Status  |  | Was Decedent of Hispanic Origin? (S<br>If Yes, specify Cuban, Mexican, Puert  |  | 14. Race - Am   | nerican Indian,  |
| 5-0036                     | n 72 hours after death with the Maryland<br>"natural", or Items 23a or 28a-f show<br>edical Examiner must be notified at   | by  | 1 Never Married XXMarried 3 Widowed 4 Divorced  | 1 ∐Yes 2 <b>XXX</b> No   | 1 ☐ Yes <b>XX</b> No <i>Specify:</i>  | o riicari, etc.)   | Specify: Wh   |  |
| 9                          | 72 hou<br>natura<br>Ical E   | ted   | 15. Decedent's E  | ducation 16a. Dece   | dent's Usual Occupation   | 10   | 6b. Kind of Busines   | s/Industry   |
| 2                          | _ 3 20   | Be Completed  | (Specify only highest gr<br>Elementary/Secondary (0-12)   | College (1-4or 5+)   | kind of work done during most of wor<br>DO NOT use retired)   | KING   |   |  |
| 21                         | ed wi<br>ygien<br>ygien<br>t. th   | ပ္ပ   |   |  | al_Superintendent   |  | Construct   | ion  |
| pu                         | be fill<br>d oth<br>even   | Be  | 17. Father's Name (First, Middle, Las   | ·  |   | ne (First, Middle, Ma  | aiden Surname)  |  |
| Σ                          | ould<br>Men<br>arke  | T <sub>o</sub>                                      | Richard J. Humph  |  | Helen S   | -  |   |  |
| Maryland                   | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meonee.  |   | 19a. Informant's Name/Relationship  | (Type. Print)   19b. Mailir  | ng Address (Street and Number or Ru   | ral Route Number,  | City or Town, State,  | , Zip Code)  |
|                            | 1 and<br>lealth<br>im 27<br>ther t   |   | Nancy Humphries   | (wife) 6721<br>20b. Place of Dispo   | Woodridge Road  | New Marke  | t, Maryla   | ind_21774  |
| altimore,                  | iges in tof h  |   | 20a. Method of Disposition 1 Burial Tremation 3   | Removal from State cemetery, crei  | natory or other place)  |  | 0c. Location - City o   |  |
| tim                        | t. Pa<br>rtmer<br>rtant:<br>njury  |   | 4 □ Donation 5 □ Other (Speci   |  |   |  |   | Maryland   |
| Bal                        | permi<br>Depar<br>Impol<br>any ir  |   | 21. Signature of Funeral Service Lice   |  | 2. Name and Address of Facility St  |  |   |  |
|                            | 222 0 0  | 1   | */ (/14/A/11) LN/   |  |   | ileo Emal  | M-  | 1 01700  |
|                            |  |   | 220 Port1 Enter the disease of the  | 71 100   | 621 Opossumtown P   |  |   | 111  |
| . 8                        |  |   | Shock, of heart landre. List offis  | nplications that chursed the death. Do not ent   |   |  |   | Approximate<br>Interval Between  |
| J                          | Physician (Modical   |   | Immediate Cause (Final disease or condition   | nplications that claused the death. Do not ent<br>y one cause on each line.  |   |  |   | Approximate  |
|                            | Physician<br>/Medical<br>Examiner  |   | Immediate Cause (Final  | nplications that cursed the death. Do not entry one cause on each line.  a. Hepatic Failure  Due to (or as a consequence of):  |   |  |   | Approximate<br>Interval Between  |
|                            | /Medical   | or.   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.  | nplications that clused the death. Do not ent<br>one cause on each line.  a. Hepatic Failure<br>Due to (or as a consequence of):<br>Renal Failure  |   |  |   | Approximate<br>Interval Between  |
|                            | /Medical<br>Examiner   | niner   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)   | nplications that clusted the death. Do not entrone cause on each line.  a. Henatic Failure Due to (or as a consequence of): Renal Failure  b. Due to (or as a consequence of):   | er the mode of dying, such as cardiac   |  |   | Approximate<br>Interval Between<br>Onset and Death   |
|                            | /Medical Examiner and I-transit  | xaminer   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate   | nplications that clused the death. Do not ent<br>one cause on each line.  a. Hepatic Failure<br>Due to (or as a consequence of):<br>Renal Failure  | er the mode of dying, such as cardiac   |  |   | Approximate<br>Interval Between  |
| 760,                       | /Medical Examiner and I-transit  | al Examiner   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | nplications that clusted the death. Do not entrone cause on each line.  a. Henatic Failure Due to (or as a consequence of): Renal Failure  Due to (or as a consequence of): c. Progressive Small   | er the mode of dying, such as cardiac   |  |   | Approximate<br>Interval Between<br>Onset and Death   |
| 68760,                     | /Medical Examiner and I-transit  | _   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | nplications that clusted the death. Do not entrone cause on each line.  a. Henatic Failure Due to (or as a consequence of): Renal Failure  Due to (or as a consequence of): c. Progressive Small   | er the mode of dying, such as cardiac   |  |   | Approximate<br>Interval Between<br>Onset and Death   |
| ox 68760,                  | Medical Examiner did by big in a continuation and continuation and se as the brutal-transit  | _   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | polications that clusted the death. Do not entry one cause on each line.  a. Henatic Failure    Due to (or as a consequence of):    Renal Failure    Due to (or as a consequence of):  c. Progressive Small Due to (or as a consequence of):  d.  23c. If yes, outcome pf pregnancy  | er the mode of dying, such as cardiac   |  | șt,   | Approximate Interval Between Onset and Death   |
| . Box 68760,               | Medical Examiner  attending physician and for use as the burial-transit  | _   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?   | nplications that clusted the death. Do not ent one cause on each line.  a. Henatic Failure Due to (or as a consequence of): Renal Failure  b. Due to (or as a consequence of): c. Progressive Small Due to (or as a consequence of): d   | er the mode of dying, such as cardiac   |  |   | Approximate Interval Between Onset and Death   |
| Box                        | death certificate be executed extending physician and extending physician and dor use as the burial-transit  | _   | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant  | nplications that clusted the death. Do not entrone cause on each line.  a. Henatic Failure Due to (or as a consequence of): Renal Failure  b. Due to (or as a consequence of): c. Progressive Small Due to (or as a consequence of): d.  23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 E  | er the mode of dying, such as cardiac  L Cell CS Lung   |  | 23d. Date of do   | Approximate Interval Between Onset and Death  10 mo  |
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| Records, P.O. Box          | e law requires that the death certificate be executed has been signed by the attending physician and le 2 should be detached for use as the burial-transit   | by Physician/Medical                                | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  | nplications that clusted the death. Do not entrone cause on each line.  a. Henatic Failure Due to (or as a consequence of):  Renal Failure  Due to (or as a consequence of):  c. Progressive Small Due to (or as a consequence of):  d.  23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 9 Unknown  | er the mode of dying, such as cardiac  L Cell CS Lung  Ectopic pregnancy Other (specify)  | 23e. Did toba 1X Yes  24a. Was an autonsy  | 23d. Date of do Month   | Approximate Interval Between Onset and Death  10 mo  elivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available occupietion of cause of   |
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| or Vital Records, P.O. Box | Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit  | To Be Completed by Physician/Medical                | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | polications that clusted the death. Do not entrone cause on each line.  a. Henatic Failure Due to (or as a consequence of): Renal Failure  b. Due to (or as a consequence of):  c. Progressive Small Due to (or as a consequence of):  d   | L Cell CS Lung  Ectopic pregnancy Other (specify)  26. Place of Dea   | 23e. Did toba  1 X Yes  24a. Was an autopsy performs  1 Yes 2  | 23d. Date of di<br>Month  acco use contribute 2  No 3 F 24b. Were a prior to death? 1  Ye  ce 6 Other (Sp   | Approximate Interval Between Onset and Death  10 mo  elivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available occupietion of cause of the second s |
| or Vital Records, P.O. Box | ding Physician: The law requires that the death certificate be executed and a After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit  | To Be Completed by Physician/Medical                | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  | polications that clusted the death. Do not entrone cause on each line.  a. Henatic Failure Due to (or as a consequence of): Renal Failure  b. Due to (or as a consequence of):  c. Progressive Small Due to (or as a consequence of):  d   | L Cell CS Lung  Ectopic pregnancy Other (specify)  26. Place of Dea   | 23e. Did toba  1 **X** Yes  24a. Was an autopsy perform 1 Yes 2 th (Check only one) ome 5 **X** Residen  | 23d. Date of di<br>Month  acco use contribute 2  No 3 F 24b. Were a prior to death? 1  Ye  ce 6 Other (Sp   | Approximate Interval Between Onset and Death  10 mo  elivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available occupietion of cause of the second s |
| or Vital Records, P.O. Box | Attending Physician: The law requires that the death certificate be executed death.  etath.  e | To Be Completed by Physician/Medical                | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | polications that classed the death. Do not entry one cause on each line.  a. Henatic Failure Due to (or as a consequence of): Renal Failure  b. Due to (or as a consequence of):  c. Progressive Small Due to (or as a consequence of):  d   | L Cell CS Lung  Ectopic pregnancy Other (specify)  aderlying cause given in Part I.  26. Place of Dea  t 3 □ DOA Other: Work? M 28c. Injury at Work? M 1 □ Yes 2 □ No | 23e. Did toba  1 X Yes  24a. Was an autopsy perform  1 Yes 2 Ith (Check only one)  ome 5 X Residen  28d. Describe how  | 23d. Date of do Month  acco use contribute 2 \( \text{No} \) 3 \( \text{F} \) F  24b. Were a prior to death? 1 \( \text{Ye} \) Ye  acc 6 \( \text{Other} \) Other (Sp   | Approximate Interval Between Onset and Death  10 mo  elivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available occupietion of cause of the second s |
| Vital Records, P.O. Box    | or Attending Physician: The law requires that the death certificate be executed iffer death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit  | To Be Completed by Physician/Medical                | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | polications that classed the death. Do not entrone cause on each line.  a. Hepatic Failure Due to (or as a consequence of): Renal Failure  b. Due to (or as a consequence of):  c. Progressive Small Due to (or as a consequence of):  d.  23c. If yes, outcome pf pregnancy 1 Live birth 2 Petal death 3 Pregnant at time of death 9 Unknown  contributing to death but not resulting in the understanding the death of the progressive state of the pregnancy of the pregnant at time of death 1 Pregnant at time of death 2 Pregnant at time of death 3 Pregnant at time of death 5 Pregnant at time of dea | L Cell CS Lung  Ectopic pregnancy Other (specify)  aderlying cause given in Part I.  26. Place of Dea  t 3 □ DOA Other: Work? M 28c. Injury at Work? M 1 □ Yes 2 □ No | 23e. Did toba  1 X Yes  24a. Was an autopsy performs 1 Yes 2 th (Check only one) ome 5 X Residen 28d. Describe how   | 23d. Date of do Month  acco use contribute 2 \( \text{No} \) 3 \( \text{F} \) F  24b. Were a prior to death? 1 \( \text{Ye} \) Ye  acc 6 \( \text{Other} \) Other (Sp   | Approximate Interval Between Onset and Death  10 mo  elivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available occompletion of cause of escales.   |
| or Vital Records, P.O. Box | Ispital or Attending Physician: The law requires that the death certificate be executed nours after death.  Inertal Director: After this certificate has been signed by the attending physician and input the funeral director, page 2 should be detached for use as the burial-transit at filled in by the funeral director.  | Certification: To Be Completed by Physician/Medical | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | polications that clusted the death. Do not entry one cause on each line.  a. Henatic Failure Due to (or as a consequence of):  Renal Failure  b. Due to (or as a consequence of):  c. Progressive Small Due to (or as a consequence of):  d  | Cell CS Lung  | 23e. Did toba  1 X Yes  24a. Was an autopsy performs 1 Yes 2  th (Check only one) ome 5 X Residen 28d. Describe how  28f. Location (Stre City or Town,   | 23d. Date of do Month  acco use contribute  2 \( \text{No} \) 3 \( \text{F} \) F  24b. Were a prior to death?  X No  24b. Were a prior to death?  Yet of the contribute  2 \( \text{No} \) 1 \( \text{Ye} \) Yet  3 \( \text{No} \) 1 \( \text{Injury occurred} \)  according to death?  3 \( \text{No} \) 1 \( \text{Injury occurred} \)  3 \( \text{Pert and Number or Foundation of State} \)  3 \( \text{State} \) 3 \( \text{Injury occurred} \) | Approximate Interval Between Onset and Death  10 mo  elivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available occompletion of cause of es 2 No  pecify)  Bural Route Number,  as stated.  |
| or Vital Records, P.O. Box | or Attending Physician: The law requires that the death certificate be executed if the death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit at by the funeral director, page 2 should be detached for use as the burial-transit.  | To Be Completed by Physician/Medical                | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner? 1   Yes XXNo  27. Manner of Death 1   Xnatural   5   Pending investigation   Suicide   4   Homicide   4   Certifying Pl | polications that clusted the death. Do not entrone cause on each line.  a. Henatic Failure Due to (or as a consequence of): Renal Failure  b. Due to (or as a consequence of):  c. Progressive Small Due to (or as a consequence of):  d.  23c. If yes, outcome pf pregnancy 1 Live birth 2 Petal death 3 Pregnant at time of death 9 Unknown  contributing to death but not resulting in the under the death of the dea | Cell CS Lung  | 23e. Did toba  1 X Yes  24a. Was an autopsy performe 1 Yes 2 1 th (Check only one) ome 5 N Residen 28d. Describe how  28f. Location (Stre City or Town, a, and due to the caurred at the time, dat | 23d. Date of do Month  acco use contribute  2 \( \text{No} \) 3 \( \text{F} \) F  24b. Were a prior to death?  X No  24b. Were a prior to death?  Yet of the contribute  2 \( \text{No} \) 1 \( \text{Ye} \) Yet  3 \( \text{No} \) 1 \( \text{Injury occurred} \)  according to death?  3 \( \text{No} \) 1 \( \text{Injury occurred} \)  3 \( \text{Pert and Number or Foundation of State} \)  3 \( \text{State} \) 3 \( \text{Injury occurred} \) | Approximate Interval Between Onset and Death  10 mo  elivery Day Year  to the cause of death?  Probably 4 Unknown autopsy findings available occupietion of cause of escify)  Rural Route Number,  as stated.  ue to the cause(s)  |

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.Gregory Rausch 501 West 7th Street Frederick, MD 21701
31. Date filed (Month, Day, Year)
32. Registrar's Signature

|                |   |                | State of Maryland / Department / Department / Department / Department / Department / Department  |  | /lental Hygi                         | ene   |  |
|----------------|---|----------------|--|--|--------------------------------------|---|--|
|                | 20  | -              | Registrar  1. Decedent's Name (First, Middle, Last)  | rtificate of Death   | Reg                                  | g. No.  | 3. Time of Death                                   |
| П              | Physici   |                |  |  | Month                                | Day Year  | M  |
|                | /Medid<br>Examir  |                | Norma Simms Harper  4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death   |                                      | 24 , 2007<br>4c. County of Death                          | 5:34 P™  |
|                |   |                | 26080 Shults Road  | Henderson  |                                      | Caroline  |  |
|                | Funeral<br>Director   |                | 5. Social Security Number  6. Sex  1 M 2 F 7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.   | 8. Date of Birth (Month, Day, 1)     | Year) 9. Birthplac  | ce (State or Foreign                               |
| ĸ,             | The sa week to the same   |                | Usual Residence of Decedent  |  | 4/23/1                               | 930   Main  | .e   |
|                | arylan<br>show  | -              | 10a. State 10b. County 10c. City, Town or Lo   |  |                                      | 100   | I. Inside City Limits                              |
|                | he Ma<br>28a-f s<br>otifie  | Director       | MD Caroline Henders  |  | 40                                   | 077   | 1 Yes 2 No   |
|                | 3a or 3   | ij             | 26080 Shults Road  | 10f. Zip Code 21640  | TO                                   | g. Citizen of What Country U.S.A.                         | / <del>!</del>                                     |
| 5-0036         | be filed within 72 hours after death with the Maryland<br>Ital Hygiene.<br>ed other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notified at | by Funeral     | 1 Never Married 2 Married 1 Tyes 2 TVNo  | Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Pueric     □ Yes 2X No Specify: | pecify Yes or No-<br>Dican, etc.)    | 14. Race - American<br>Black, White, etc<br>Specify: Whit | o.   |
| 1215-0         | within 72 ho<br>ene.<br>than "natu<br>ne Medical  | Completed      | (Specify only highest grade completed) (Give   Elementary/Secondary (0-12)   College (1-4or 5+)  | dent's Usual Occupation kind of work done during most of work DO NOT use retired)                    | king                                 | 6b. Kind of Business/indu                                 |  |
| 0              | 12 should be filed w<br>n and Mental Hygie<br>is marked other th<br>raumatic event, th  | ပ္ပ            | 12 Tow   | n Manager<br>18. Mother's Nam  | e (First, Middle, Ma                 | Municipal aiden Surname)                                  | Gov't  |
| Maryland       | Suld be<br>Mental<br>arked o  | To Be          | Harley Smith Simms   | Cathor   | ina Alr                              | meda Mill   | or   |
| lary           | 2 shou<br>and N<br>is mai   |                | _  | ng Address (Street and Number or Rui   |                                      |   |  |
|                | s t and 2 should<br>if Health and Mer<br>item 27 is marke<br>other traumatic  |                | Peggy H. Betch/ daughter 260 20a. Method of Disposition 20b. Place of Dispo  | 080 Shults Road  | ; Hende                              | rson, MD 2<br>Oc. Location - City or Town                 | 1640   |
| 0<br>0         | 0 0   |                | 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State cemetery, cree   | matory or other place)   |                                      |   | , otato  |
| altimore,      | permit. Pag<br>Department<br>Important: I<br>any injury o   |                | Od Cincohor of Extract Consider Lineares   | None and Address of Essilia  |                                      | Chester, M  |  |
| ñ              | Der Jany  | l) li          | Hart ( Klay F  | legle and Hel:   | fenbein<br>nsboro                    | Funeral H   | ome,PA   |
|                | Physician   |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause neach line.  Immediate Cause (Final disease or condition resulting in death)  | er the mode of dying, such as cardiac  | or respiratory arres                 | boleera /   | opproximate<br>Interval Between<br>Onset and Death |
|                | /Medical<br>Examiner  |                | Due to (or as a consequence of).   | 0  |                                      |   |  |
|                |   | ner            | Squentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   |  |                                      |   |  |
|                | ecute<br>and<br>trans   | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last  |  |                                      |   |  |
| 8760,          | cate be executed physician and the burial-transit   | al E           | Due to (or as a consequence of):   |  |                                      |   |  |
| 68/            | cate<br>phy:  | edical         | d  |  |                                      |   |  |
| O. Box         | the death certifi<br>/ the attending  <br>ched for use as   | Physician/Me   |  | Ectopic pregnancy Other (specify)  |                                      | 23d. Date of delivery<br>Month D                          | ay Year  |
| rds, P         | The law requires that the date has been signed by the vage 2 should be detached   | by             | Part II. Other significant conditions contributing to death but not resulting in the u   | nderlying cause given in Part I.   | 23e. Did toba                        | acco use contribute to the                                | cause of death?                                    |
| Vital Records, | The lay<br>ate has<br>bage 2  | Completed      |  |  | 24a. Was an autopsy perform          | prior to comp<br>death?                                   | y findings available letion of cause of            |
| VITA           | ician;<br>certific<br>ector,  | Be             | 25. Was case referred to medical examiner?  1. Type 2. Type 1. Hospital: 4. Type 1. Ty | Othor:   | th (Check only one)                  | )   |  |
| ō              | ding Phys<br>h.<br>After this<br>funeral dir  | . To           | 1 ☐ Yes 2 ☑ Wo ☐ 1 ☐ Inpatient 2 ☐ ER/Outpatier  27. Manper of Death   |  | ome 5 Residen<br>28d. Describe how   | ce 6 Other (Specify)                                      |  |
| <u>0</u>       | nding<br>ath.<br>r: Afte<br>e fune  | ation          | 1 XNatural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation   | f 28c. Injury at Work?  M 1 Yes 2 No   |                                      |   |  |
| DIVISION       | tal or Atte<br>s after dec<br>al Directo<br>ed in by th   | Certification: | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, str building, etc. (Specify)  | eet, factory, office   | 28f. Location (Stre<br>City or Town, | eet and Number or Rural F<br>State)                       | Route Number,                                      |
|                | To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifics completely filled in by the funeral director, to applicable.  | Medical (      | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deatted the control of the control of the pasts of examination and/or in and manner stated.  | n occurred at the time, date and place,<br>vestigation, in my opinion, death occu                    | and due to the cau                   | use(s) and manner as stat<br>te and place, and due to the | ed.<br>ne cause(s)                                 |
| )              | To t<br>withi<br>To ti  | Σ              | 29b. Signature and title of certifier  The signature and title of certifier  W.  | 29c. License number  D17036 - /  | Nd - 7                               | d. Daye signed (Month, Da                                 | ay, Year)  |
|                |   |                | 30. Name and address of person who completed cause of death (Item 23a) (Type, 50s on K Rossin D 566 Was hing   |  | rfon t                               | nd 21620  | 1  |
| 336.3          | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year)  32. Registrar's Signature  31. Date filed (Month, Day, Year)  | South)   |                                      |   |  |

|                            |   |                     | For<br>State<br>Registrar   | State of Ma   | aryland                           |                        | artmen<br>rtificati                  |                      |                                   |               |                            | giene<br>Reg. No.                       | UUI                                       | 2508   |
|----------------------------|---|---------------------|---|---|-----------------------------------|------------------------|--------------------------------------|----------------------|-----------------------------------|---------------|----------------------------|---|---|--|
|                            | Physicia  |                     | 1. Decedent's Name (First, Midd   |   |                                   |                        |                                      |                      |                                   | 2.            | Date of Dea                | ath<br>Day                              | Year                                      | 3. Time of Death                                 |
|                            | /Medic  |                     | THEODORE ALVAR HAAPALA, JR.   |   |                                   |                        |                                      |                      |                                   | -             |                            | 24 2                                    | 7007                                      | 17204  |
|                            | Examin  | er                  | 4a. Facility Name (If not institution  +H & M & E M   |   | SPI                               | <del>-1</del> 1/       | 4b. City,                            |                      | Location<br>AS 7                  |               |                            | _                                       | nty of Death<br>ALBO                      | 7  |
|                            | Funeral   | 2                   | 5. Social Security Number   | - / /   |                                   | ast birthday)          | If Under                             | 1 Year               | If Under                          | 24 Hrs   0    | Date of Birt               | h                                       |   | place (State or Foreign                          |
| - 10                       | Director  |                     | 216-38-8168   | 1 🗗 M 2 🗆 F   | 66                                | Yrs.                   | Months                               | Days                 | Hours                             | Min.          | (Month, Day<br>MAR 10      | , 1941                                  | MAS                                       | SS.  |
| \                          | and   | }                   | Usual Residence of Decedent  10a. State 10b. County   | /   | 10c. City                         | , Town or Lo           | cation                               |                      |                                   |               |                            |   | 1   | 10d. Inside City Limits                          |
| G,                         | Maryl<br>-f sho<br>ied a  | tor                 | MD CAR  | OLINE   |                                   | GREENS                 | SBORO                                |                      |                                   |               |                            |   |   | 1XTYes 2□No                                      |
| à                          | or 28a  | )irec               | 10e. Street and Number  |   |                                   |                        | 10f. Zip                             | Code                 |                                   | ****          |                            | 10g. Citizen o                          | f What Cour                               | ntry?  |
| RODOR                      | ath wi  | ral                 | 12030 OVERLOO   |   |                                   |                        |                                      | 2163                 |                                   |               |                            |   | USA                                       |  |
| # 6<br>036                 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status  1 ☐ Never Married 2 ☒ Mai 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give  |                                   |                        | Was Deced<br>If Yes, sped<br>1 ☐ Yes |                      | spanic Or<br>n, Mexica<br>Specify |               | y Yes or No-<br>can, etc.) | Spec                                    | ace - Americ<br>lack, White,<br>cify: WH] | etc.   |
| 26                         | 72 ho<br>'natur<br>dical  | eted                | 15. Decede<br>(Specify only high  | nt's Education<br>est grade completed)                              |                                   | 16a. Dece              | dent's Usua<br>kind of wo            | l Occupa<br>k done d | ition<br><i>uring mo</i> s        | st of working |                            | 16b. Kind of                            | Business/In                               | dustry   |
| 7AL<br>2121                | within<br>iene.<br>than "   | mpl                 | Elementary/Secondary (0-12)   | College (1-4or 5  | i+)                               |                        |                                      |                      |                                   | GINEER        |                            | DEFE                                    | NSE                                       |  |
|                            | Hygi<br>other<br>ent, tl  | To Be Completed by  | 17. Father's Name (First, Middle  |   |                                   |                        |                                      |                      |                                   |               | irst, Middle,              | Maiden Surn                             |   |  |
| 3A<br>Ilan                 | 2 should be and Mental is marked o  | 9 P                 | THEODORE A. H   | AAPALA, SR.   |                                   |                        |                                      |                      | EI                                | LLEN H        | . TAIV                     | AL                                      |   |  |
| #AA F<br>Maryland          | 2 sho   |                     | 19a. Informant's Name/Relation  |   |                                   |                        | -                                    |                      |                                   |               |                            | er, City or Tow                         |   | Code)  |
|                            | 1 and 2<br>Health<br>em 27<br>wher tr   |                     | CHERYL HAAPALA 20a. Method of Disposition   | /WIFE   | 20b. PI                           | 12030<br>lace of Dispo |                                      |                      |                                   | Dat           |                            | 20c. Location                           |   | own, State                                       |
| Baltimore                  | Pages<br>nent of<br>int: If Its<br>iny or o   |                     | 1 M Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (  |   |                                   | emetery, crei<br>VETER |                                      |                      | 9) :                              | 7/31/         | 2007                       | HIIRT.O                                 | ск, м                                     | 0  |
| altir                      | permit. Pag<br>Department<br>Important: I<br>any Injury o   |                     | 21. Signature of Funeral Service  |   | TID                               | 2:                     | 2. Name an                           | d Addres             | s of Facil                        | itv           |                            |   |   |  |
| <u> </u>                   | Per La  |                     | Joseph M.   | 03,30031, 0.  |                                   |                        | 200_S                                | _HAI                 | RRISC                             | ON ST.        | , EAST                     | ON, MD                                  | 2160                                      | HOME PA<br>l                                     |
|                            | Physician   |                     | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death  APPREST  Due to (or as a consequence of): |   |                                   |                        |                                      |                      |                                   |               |                            |   |   |  |
|                            | /Medicai<br>Examiner  |                     | resulting in death)   |   | a consequ                         | uence of):             | AN T                                 | Fan                  | 2 3                               | ı             |                            |   |   |  |
|                            | 2 15  | Jer                 | Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury   | b. Due to (or se  | ESTER<br>a consequ                |                        | ×11/1                                | ( -75                | LLEN                              | <u></u>       |                            |   |   |  |
|                            | scuted<br>nd<br>rransit   | Examiner            | Cause (Disease or injury that initiated events resulting in death) Last   | C. REGH   |                                   |                        | 2CULO)                               | n                    | Her                               | 2111121       | PUGO                       |   |   |  |
| 60,                        | icate be executed<br>physician and<br>s the burial-transit  | E                   | resulting in death) Last  | Due to (or as   | a consequ                         | uence of):             |                                      |                      |                                   |               |                            |   |   |  |
| 68760,                     | icate t   | edical              |   | d   |                                   |                        |                                      |                      |                                   |               |                            |   |   |  |
| P.O. Box (                 | Attending Physician: The law requires that the death certificate be executed reath.  sctor: After this certificate has been signed by the attending physician and sy the funeral director, page 2 should be detached for use as the burial-transit  | Physician/Me        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome pr pregnancy in the past 12 months? 1          |                                   |                        |                                      |                      |                                   |               |                            | 23d. Date of delivery<br>Month Day Year |   |  |
| ς,<br>-                    | signed b  | by Pr               | Part il. Other significant condit   | ions contributing to death b  | ut not resu                       | ilting in the u        | nderlying c                          | ause giv <b>e</b>    | n in Part                         | i.            | 23e. Did to                | obacco use co                           | ontribute to t                            | he cause of death?                               |
| ord                        | w require<br>been sig<br>should b   |                     |   |   |                                   |                        |                                      |                      |                                   |               | 1 🗆 1                      | res 2□ No                               | 3 ☐ Prob                                  | bably 4 binknown                                 |
| ec.                        | e law<br>has b  | Completed           |   |   |                                   |                        |                                      |                      |                                   |               | 24a, Was                   |   | b. Were auto<br>prior to co<br>death?     | opsy findings available<br>empletion of cause of |
| <u>a</u>                   | iclan: The<br>certificate ha<br>ector, page   |                     | OF Man area referred to madic   | -1  |                                   |                        |                                      |                      |                                   |               | 1□ Yes                     | 211No                                   | 1 ☐ Yes                                   | 2 No   |
| Ž                          | /siclan:<br>s certific<br>director,   | To Be               | 25. Was case referred to medic examiner?  1 ☐ Yes 2 ☐ No  | Hospital: 1 Inpatie   | ent 2                             | Doutpatie              | nt 3□ DC                             | Othe                 | · F.                              |               | Check only o               | ne)<br>dence 6 □C                       | Other (Sneci                              | fv)  |
| 10 U                       | ding Phys<br>h.<br>After this<br>funeral dir  |                     | 27. Manner of Death  1 ☐ Natural 5 ☐ Pendi  | 28a. Date of Inju   | iry                               | 28b. Time o            |                                      | 8c. Injury<br>Work   |                                   |               |                            | now injury occ                          |   | 3/   |
| siol                       | ttendir<br>death.<br>ctor: A:<br>/ the fu   | catic               | 2 Accident invest   | igation   |                                   |                        | М                                    | 101                  | res 2□                            |               |                            |   |   |  |
| Division or Vital Records, | or At<br>after d<br>Direct<br>in by   | Certification:      |   | mined 28e. Place of injusting, et                                   | ury - At ho<br>c. <i>(Specify</i> | me, farm, sti          | reet, factory                        | , office             |                                   | 28            | Location (S<br>City or Tov | Street and Nui<br>vn, State)            | mber or Rur                               | al Route Number,                                 |
|                            | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu  | Medical Co          |   | ing Physician: To the best I Examiner: On the basis o and manner st | f examinat                        |                        |                                      |                      |                                   |               |                            |   |   |  |
|                            | ro the vithin i or the omple  | Mec                 | 29b. Signature and title of certifi   |   | uiou.                             |                        | 290                                  | . License            | number                            |               | 1                          | 29d. Date sig                           | ned (Month,                               | Day, Year)                                       |
|                            | L > F 0   |                     | Them  | 2   |                                   |                        | I                                    | 200                  | 63                                | 018           |                            | 7/20                                    | 4/07                                      | 1  |
| 15                         | 2+11/4  |                     | 30. Name and address of person  |   |                                   |                        |                                      |                      |                                   |               |                            |   | , - 1                                     |  |
| 10                         |   |                     | FRANK PETER   | CIOCCI M.D.   | 219 S                             | WAS                    | HINGT                                | ON S                 | r., 1                             | EASTON        | , MD 2                     | 1601                                    |   |  |
|                            | Sta<br>Registr  |                     | 31. Date filed (Month, Day, Yea   | 2007 Registr  | ar a Gigital                      | ture                   | 1                                    |                      |                                   |               |                            |   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yeer **Physician** 4:10AM M WENDELL P. HOLMAN, JR. JULY 29 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner WILLIAM HILL MANOR EASTON TALBOT If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral X**□M 2□ F Yrs. Director 74 DEC 14,1932 NEW YORK 129-28-1790 Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits Item 27 le marked other then "naturel", or Iteme 23a or 28e-f show other treumetic event, the Medical Examinar must be inclined at 1 ☐ Yes 2√ No Director DE SUSSEX FRANKFORT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 34769 LINCOLN DRIVE 19945 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify: 3 ☐ Widowed 4 X Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Importent: If item 27 ie marked other then any injury or other treumetic event Elementary/Secondary (0-12) College (1-4or 5+) LT. COL U.S. ARMY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WENDELL P. HOLMAN, SR. NORMA JEAN DEMAREST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W.P.HOLMAN/SON 51 GREENBACK CT., PERRYVILLE, MARYLAND 21903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State `4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 7/30/2007 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 S. HARRISON ST., EASTON, MD 21601 HOME PA JOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Surriam Physician Metastate ZWOW /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown signed by Part 从 Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Tes 2. No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 1 ☐ Yes 2 ☐ Mo this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death | Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

8+UA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WILLIAM H. WOOD, JR., M.D., 501 DUTCHMANS LANE, EASTON, MD 21601

State Registrar MI)

D08/13

29/8

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 37, Joan Ann Hardee Tulu 2007 9:10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Caroline Home for Hospice Denton Caroline 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours Min. 1 □ M 2 □ F 216-34-0166 August 28, 1936 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h County 1 ☐ Yes 2 ☐ No Maryland Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 Market Street 21629 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Caucasian 3₺ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Stanislavs Nehring Dorothy Victoria Majka 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Hardee Son 613 Market Street, Denton, Maryland 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/3/2007 4 □ Donation 5 □ Other (Specify) Denton Cemetery Denton, Maryland 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Denton, Maryland 21629 Approximate Interval Between Onset and Death WEEKS

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

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P

lm dis res

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature!" any injury or other traumatic executions.

nding physician and use as the burial-tran

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Physician/Medical Examiner IE 23 Completed by ä

| shock, or heart failure. List o  | only one cause on each line.   | atory arrest, |
|--|--|---------------|
| mediate Cause (Final<br>ease or condition<br>sulting in death)                   | a RENAL FAILURE  |               |
| during in death)   | Due to (or as a consequence of):   |               |
| quentially list conditions,<br>ny, leading to immediate<br>use. Enter Underlying | Due to (or as a consequence of):   |               |
| use (Disease or injury<br>t initiated events<br>ulting in death) Last            | cDue to (or as a consequence of):  |               |
|  | d  |               |
| FEMALE:  b. Was decedent pregnant in the past 12 months? 1 Yes 2 No              | 23c. If yes, outcome pf pregnancy  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  4 □ Pregnant at time of death 5 □ Other (specify) | 23d.          |

| $\geq$        | 9 Unknown*   |   |                                     |                                     |   |  |  |  |  |  |  |  |
|---------------|--|---|-------------------------------------|-------------------------------------|---|--|--|--|--|--|--|--|
| ted by Phy    | Part II. Other significant conditions of                             | contributing to death but not res   | sulting in the underlyin            | g cause given in Part I.            |   | use contribute to the cause of death?  |  |  |  |  |  |  |
| Complete      |  |   |                                     |                                     | 24a. Was an autopsy performed? 1  Yes 2 No      | 24b. Were autopsy findings availab prior to completion of cause of death? 1 □ Yes 2 □ No |  |  |  |  |  |  |
| Be            | 25. Was case referred to medical examiner?                           |   | 26. Place of Death (Check only one) |                                     |   |  |  |  |  |  |  |  |
| To E          | 1 ☐ Yes 2 No   | Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   Other (Specify) |                                     |                                     |   |  |  |  |  |  |  |  |
|               | 27. Manner of Death 1XNatural 5 □ Pending 2 □ Accident investigation | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury<br>M         | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how injur                         | 6 Kother (Specify)<br>y occurred Hospice   |  |  |  |  |  |  |
| Certification | 3 Suicide 6 Could not be<br>4 Homicide determined                    | 28e. Place of injury - At h<br>building, etc. (Speci  |                                     | tory, office                        | 28f. Location (Street an<br>City or Town, State | d Number or Rural Route Number,<br>)   |  |  |  |  |  |  |
| edical (      |  | ysician: To the best of my kn<br>niner: On the basis of examin<br>and manner stated.                          |                                     |                                     |   | and manner as stated.<br>d place, and due to the cause(s)                                |  |  |  |  |  |  |
| ž             | 29h. Signature and title of certifier                                |   |                                     | 29c. License number                 | 29d. Dat  | te signed (Month, Day, Year)   |  |  |  |  |  |  |

(Check only one) 29b. Signature and titl

0053815

29d. Date signed (Month, Day, Year) 2007

Date of delivery

Month

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Konah Pulimood, 31. Date filed (Month, Day, Year) M.D

912 Market Street. Denton, Maryland 21629 32. Registrar's Signature

ALIF

State

Registra

within 24 hours after

To the Funeral Dire

completely filled in by

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Pay **Physician** August 2007 2:40 PM Johnson Marleen Marie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Hagerstown <u> 271 S. Prospect St.</u> 8. Date of Birth (Month, Day, Year) Nov. 16, 1 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 71 Director 220-30-9721 1935 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or Items 23e or 28e-1 show treumatic event, it s Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director Washington Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 271 South Prospect Street Apt#4 21742 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married □Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within nd Mental Hygiene. marked other then Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be filt treent of Health and Mental Hytent: If item 27 Is marked oth Be Charles Russell Davis *Aletta Corwell* 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Riker 22412 Goose St. Smithsburg, Maryland 21783 (Son) other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State August ō permit. Page Department of Importent: If eny injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2007 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home Mol4/4 | 12525 Bradbury Ave. Smithsburg, Maryland 21783 L)Avis Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 Years Immediate Cause (Final **Physician** years. disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Dav 4 Pregnant at time of death 5 Other (specify) the a 9 Unknown The taw requires that the 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page this certificate 1 ☐ Yes 2 1 No or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death the 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29d. Date signed (Month. Dav. Year) 29c. License number 05/282 1 at mo 07 10 21795 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Williamsport Family Practice 3 Byrkit Dr. Williamsport, MD Dr. Sammuel Rao 31. Date filed (Month, Day, Year) Registrar's Signature State 1 6 2007 Registrar

|   |  |                | State of Maryland / [  1 - State Registrar   | Department of F<br>Certificate of                |   |                                       | iene<br>eg. No. ( )       | ***   |
|---|--|----------------|--|--|---|---------------------------------------|---------------------------|---|
|   |  |                | Decedent's Name (First, Middle, Last)  |  | 2. Date of Death                        | h                                     | 3. Time of Death          |   |
|   | Physici  |                | LENORE M. JEWLER   |  |   | Month<br>AUGUST                       | Day 2007                  | 1:30 P M  |
| Mar.  | /Medic<br>Examín   |                | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, o                                | r Location of Death                     | 110 00 01                             | 4c. County of D           |   |
|   |  |                | CASEY HOUSE  | ROCKVILI   | LE                                      |                                       | MONTGOME                  | ERY   |
| - (-) ·   | Funeral  |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last bit  | Months Days                                      | If Under 24 Hrs.<br>Hours Min.          | 8. Date of Birth (Month, Day, 11/17/1 | Year) 9. I                | Birthplace (State or Foreign<br>Country)                |
| ١.  | Director   |                | 5/9-09-3685  | Yrs.   |   | 11/17/1                               | 919 MA                    | ARYLÁND   |
| 700   | <b>2 ≥</b>   |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow   | n or Location                                    |   |                                       |                           | 10d. Inside City Limits                                 |
| Many  | fsho   | jo             | MARYLAND MONTGOMERY KENSIN   | CTON   |   |                                       |                           | Maryes 2 No   |
| d d   | r 28a  | Director       | 10e. Street and Number   | 10f. Zip Code                                    |   | 10                                    | Og. Citizen of What       | Country?  |
| , with  | 23a o<br>st be   |                | 3620 LITTLEDALE ROAD APT109  |  | 20895                                   |                                       | U.S.A                     |   |
| to de   | ems (  | Funeral        | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?   | 13. Was Decedent of H                            | lispanic Origin? (Span. Mexican, Puerto | ecify Yes or No-<br>Bican, etc.)      | 14. Race - A<br>Black, W  | merican Indian,   |
| ထွ  | or its   | y Fu           | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No<br>☐ If Yes, Give  | 1 ☐ Yes 21 No                                    | Specify:                                | , 2.2.,                               | Specify: W                |   |
| d 21215-0036<br>flood within 72 bours after death with the Manyland | ural   | d by           | 3X Widowed 4 □ Divorced Year or Dates:   | Decedent's Usual Occup                           | action                                  |                                       | 16b. Kind of Busine       |   |
| <u> </u>  | " "nat   | Completed      | (Specify only highest grade completed)   | (Give kind of work done life. DO NOT use retired | during most of work                     | ing                                   | 160. Killu of Busine      | ss/mustry   |
| 72  | iene.<br>r thar<br>the N   | mo             | Elementary/Secondary (0-12) College (1-4or 5+)   | HOMEMAKI   | ER                                      |                                       | OWN H                     | IOME  |
| פַ יַּי   | othe<br>vent,  | Be C           | 17. Father's Name (First, Middle, Last)  |  | 18. Mother's Name                       | e (First, Middle, N                   |                           |   |
| arylar<br>should by   | anous one was when the property of the propert | To E           | MAX SHAFFER  |  | ESTHER I                                | KATZENEL                              | L                         |   |
| Maryland 21215-0036   |  |                | , , , , ,  | . Mailing Address (Street                        |   |                                       | ,                         |   |
|   | ealth<br>m 27<br>her tr  |                |  | U4U DOOLITII  f Disposition (Name of             |   |                                       |                           | AGE, MD 20886   |
| altimore,   | rages ranent of Heannart: If item  |                | 1 ဩrBurial 2 □ Cremation 3 □ Removal from State cemete   | ry, crematory or other pla                       | ce)                                     |                                       | 20c. Location - City      |   |
| tim<br>F  | rtmen<br>rtant:<br>njury   | 1.8            | 4 □ Donation 5 □ Other (Specify) MOUN'T  21. Signature of Eureral Service Licensee   | LEBANON CEME                                     |   |                                       |                           |   |
| Balti   | Department of Important: If it any injury or conce.  | l, l           | 21. Sy nature of wherai Service Licensee   | EDWARD SAC                                       | GEL FUNERA                              | AL DIRECT                             | TION, INC                 | VI AND 20052  |
|   | -35  | 7              | 23a. Part. Enter the disease, or complications that caused the death. Do shock, or heart latture. List only one cause on each line.  | 1091 ROCKY                                       |   |                                       |                           | Approximate   |
|   | hysician   | į ir           | Immediate Cause (Final   |  |   |                                       |                           | Interval Between<br>Onset and Death                     |
|   | /Medical   |                | disease or condition resulting in death)  SEPSIS SYNDROME  Due to (or as a consequence   | of):   |   |                                       |                           |   |
| E   | xaminer  |                | Sequentially list conditions b.  |  |   |                                       |                           |   |
| 1 7   | - <del>-</del>   | iner           | if any, leading to immediate Due to (or as a consequence cause. Enter Underlying   | of):   |   |                                       |                           |   |
| 20, 5   | and<br>-trans  | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last C  | of)-   |   |                                       |                           |   |
| 8760, 7/  | physician and<br>s the burial-transit  | a<br>E         | bue to (or as a consequence  | 01).   |   |                                       |                           |   |
|   | phys<br>s the  | edical         | d  |  |   |                                       |                           |   |
| X   | nding<br>use a   | N/M            | IF FEMALE: 23c. If yes, outcome pf pregnancy   |  |   |                                       | 23d. Date of              | delivery  |
| P.O. Box  | e atte   | Physician/Me   | in the past 12 months?  1 Ves. 2 No. 4 Pregnant at time of death   | 3 ☐ Ectopic pregnanc<br>5 ☐ Other (specify) _    | у                                       |                                       | Month                     | Day Year  |
| 0 1   | by the   | hys            | 9 ☐ Unknown  |  |   |                                       |                           |   |
| Records, P.O. Box 6   | igned by the attending place as detached for use as  |                | Part II. Other significant conditions contributing to death but not resulting i  | n the underlying cause giv                       | en in Part I.                           |                                       |                           | e to the cause of death?                                |
| ord   | been si  | ted            | ACUTE RENAL FAILURE  |  |   | 1 ∐ Ye                                | es 2 k∏ No 3 □            | Probably 4 Unknown                                      |
| ec  | has bu   | Completed by   |  |  |   | 24a. Was ar<br>autops                 | y prior                   | autopsy findings available<br>to completion of cause of |
|   |  | Con            |  |  |   | perform<br>1∐ Yes 2                   | ned? death<br>2  No 1 □ \ |   |
| Vit.  | is certificate he director, page   | Be             | 25. Was case referred to medical examiner?  1 Type 2 Type Hospital: 4 Type 2 Type 1 Type 2 Ty | structions 2 DOA Oth                             | 26. Place of Deat                       | h (Check only one                     | e)                        | HOSPICE   |
| o a   | After this<br>funeral di   | - L            | 27. Manner of Death 28a. Date of Injury 28b.   | Time of 28c. Injur                               | 4 □ Nursing Hory at                     | me 5 L Reside                         | ence 6 & Other (S         | Specify HOME  |
| on a  | th.<br>: After th<br>s funeral   | tion           | 1 ⊠Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation  |  | rk?<br> Yes 2 □ No                      |                                       |                           |   |
| Division or   | er death<br>ector: v   | ifica          | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, fa building, etc. (Specify)   | arm, street, factory, office                     |   | 28f. Location (Str.<br>City or Town   |                           | r Rural Route Number,                                   |
| בַּ   | rs afte  | Certification: | building, etc. (opeciny)   |  |   | Only of Town                          | , olate)                  |   |
| Joen  | Funer<br>Funer<br>ely fill   |                | 29a. Certifier  (Check only  1   Certifying Physician: To the best of my knowledg  2   Medical Examiner: On the basis of examination ar  |  |   |                                       |                           |   |
| Division or Vita  | within 24 hours after death  To the Funeral Director: completely filled in by the  | Medical        | one) and manner stated.  29b. Signature and title of certifier /   | 29c. Licens                                      | se number                               | 29                                    | 9d. Date signed <i>(M</i> | onth Day Year   |
| F   | 5 <u>1</u> ≥ 00  | -              | 250. Signature and the street of the last  |  | 64615                                   |                                       | V                         |   |
|   |  |                | 30, Name and address of person who completed cause of death (Item 23a)   |  | 7910                                    |                                       | 0110                      | TUK   |
|   | 9  |                | DR, GENEVIEVE WROBLEWSKI, 6001 MUN   |  | RD, ROCKV                               | VILLE, MA                             | ARYLAND                   | 20855   |
|   | Sta  | ite            | 31 Date filed (Month Day Year) 82 Begistrar's Signature  |  |   | <u> </u>                              |                           |   |
|   | Regist   | ar             | NIG 1 6 2007 Serve & A   | besse  |   |                                       |                           |   |

|  |  |                  | For<br>Stata<br>Registrar   |  |                                  | ind / Dep                          |                              | of H                    | ealth a                  |            | lental Hy                                |                               | 007                           | 2:30)  |
|--|--|------------------|---|--|----------------------------------|------------------------------------|------------------------------|-------------------------|--------------------------|------------|--|-------------------------------|-------------------------------|--|
|  | 300  |                  | Decedent's Name (First, Middle, La  | ist)   |                                  |                                    |                              |                         |                          |            | 2. Date of De                            | ath                           |                               | 3. Time of Death                               |
|  | Physicia<br>/Medic   |                  |   | Steph  | en E.                            | Jablon                             | ski                          |                         |                          |            | Month<br>August                          | Day<br>4+h                    | Year                          | 11:51 A M                                      |
|  | Examin   |                  | 4a. Facility Name (If not institution, gi   | ve street and num                                | iber)                            |                                    | 4b. City,                    | Fown, or                | Location of              | of Death   | 0  | 4c. Cou                       | nty of Death                  |  |
|  |  |                  | Union Hospital  |  |                                  |                                    |                              | ton                     |                          |            |  |                               | eci1                          |  |
|  | Funeral<br>Director  |                  | ,   | Sex<br>1 <b>∑</b> M 2 □ F                        | 7. Age (In yr<br>69              | s. last birthday,<br>Yrs.          | Months                       | Days                    | If Under<br>Hours        | Min.       | 8. Date of Bird<br>(Month, Da<br>OCT 30, | y, Year)<br>1937              | 9. Birtho<br>Cour<br>New      | place (State or Foreign<br>ntry)<br>York       |
|  | pug 🛊  |                  | Usual Residence of Decedent  10a, State 10b, County   |  | 100.0                            | City, Town or L                    | ocation                      |                         |                          |            |  |                               | 1                             | I 0d. Inside City Limits                       |
|  | Aaryla<br>reho   | 5                |   | 1  |                                  | Broomal:                           |                              |                         |                          |            |  |                               |                               | 1 ☐ Yes 2 🕅 No                                 |
|  | death with the Maryland<br>ms 23s or 28s-f show  | Director         | Pennsylvania De   | laware   |                                  | oroomar.                           | 10f. Zip                     | Code                    | ·                        |            |  | 10g. Citizen                  | of What Cour                  | ntry?  |
|  | 38 or  |                  | 522 Warren Boule  | vard   |                                  |                                    | 10                           | 8008                    |                          |            |  | Unit                          | ed Sta                        | ates   |
| 5                                      | deat   | Funeral          | 11. Marital Status  | 12. Was Dece                                     | dent Ever in                     | U.S. 13.                           |                              |                         | spanic Ori               | gin? (Spe  | ecify Yes or No<br>Rican, etc.)          |                               | Race - Americ                 | can Indian,                                    |
| 0036<br>0036                           | within 72 hours after death with the Marylan<br>ane.<br>then "naturel", or Items 23e or 28e-1 e how<br>the Madical Examiner must be notified at  |                  | 1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced  | 1 ☐ Yes<br>If Yes, Give<br>Year or Da            | 2 XI No                          |                                    | 1 ☐ Yes 2                    |                         | Specify:                 | , 1 00110  | riouri, oto.,                            |                               | ocity: Whi                    |  |
| 5-0                                    | 72 ho  | Completed by     | 15. Decedent's E<br>(Specify only highest gr  | ducation   |                                  | 16a. Dece                          | dent's Usua                  | l Occupa                | tion<br>uring mos        | t of worki | na                                       | 16b. Kind o                   | f Business/In                 | dustry   |
| 21215                                  |  | mpie             | Elementary/Secondary (0-12)   | College (1-                                      | 4or 5+)                          |                                    | kind of wor<br>DO NOT us     |                         |                          |            | 9  | _                             |                               |  |
| 2                                      | Tygie<br>Ther t  | S.               | 12<br>17. Father's Name (First, Middle, Las   | *)   |                                  | Sa                                 | lesmar                       |                         | 18 Mothe                 | r'e Name   | (First, Middle,                          |                               |                               | on Supply                                      |
| Maryland                               | d be f   | ă                | Stephen C. Jablo  | •  |                                  |                                    |                              |                         |                          |            | e Ladan                                  |                               | iairie)                       |  |
| az K                                   | Shoul<br>nd Me<br>mari   | ۵                | 19a. Informant's Name/Relationship  |  |                                  | 19b. Maili                         | ing Address                  | (Street a               |                          |            | I Route Numbe                            |                               | wn, State, Zip                | Code)  |
|  | alth a   |                  | Stephen C. Jablo  | nski/Son   |                                  | 1801                               | But1e                        | er Pi                   | ike,                     | #131       | , Consh                                  | ohocke                        | en, PA                        | 19428  |
| Jable altimore,                        | of Health<br>Item 27   | Ī                | 20a. Method of Disposition  | 78   | 20b                              | . Place of Disp                    | osition (Nam                 | e of<br>her place       | ) l                      | Δ11G11     | st 9,                                    | 20c. Locatio                  | on - City or To               | own, State                                     |
| in A                                   | Page<br>ment: If<br>ury or   |                  | 1 X Burial 2 ☐ Cremation 3 [<br>4 ☐ Donation 5 ☐ Other (Speci   |  | Sa Sa                            | cemetery, creatints Paul Cem       | etér a<br>eterv              | ind                     |                          | 2007       |  | Brooma                        | 11. P/                        |  |
| Balt                                   | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 le marked other then any injury or other traumatic event, the Modes.   |                  | 21. Signature of Funeral Service Lice   | nsee   |                                  | H                                  | 2. Name and<br>ICKS          | Address<br>Iome         | for                      | Fune       | rals, P<br>, Elkto                       | .A.                           |                               |  |
|  |  |                  | 23a. Part1. Enter the disease, or con shock, or heart failure. List only  | plications that ca                               | used the de                      |                                    |                              |                         |                          |            |  |                               | 21921                         | Approximate<br>Interval Between                |
|  | Physician  |                  | Immediate Cause (Final disease or condition   | one cause on ea                                  | ich line.                        | -1 -                               | ^                            | ,                       | ion                      |            |  |                               | 6                             | Onset and Death                                |
|  | /Medical   |                  | resulting in death)   | Due to   | Das a conse                      | equence of):                       | inta                         | rct                     | 100                      |            |  |                               |                               | minutes  |
|  | Examiner   |                  | Sequentially list conditions.   | b  | Contraction of the               |                                    |                              |                         |                          |            |  |                               |                               |  |
| 1                                      | sit ad   | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (   | or as a cons                     | equence of).                       |                              |                         |                          |            |  |                               |                               |  |
| Ma                                     | sician and burial-transit  | Examiner         | that initiated events resulting in death) Last  | c.<br>Due to (c                                  | or as a conse                    | equence of):                       |                              |                         |                          |            |  |                               |                               |  |
| 760,                                   | sician<br>ysician<br>e buria   | caiE             |   |  |                                  | - 4                                |                              |                         |                          |            |  |                               |                               |  |
| 687                                    | 2 20 1   |                  |   | _ d  |                                  |                                    |                              |                         |                          |            |  |                               |                               |  |
| ŏ                                      | n certi  | 2                | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outo                                |                                  |                                    | 75                           |                         |                          |            |  | 23d.                          | Date of delive                | ery  |
| Ö.                                     | death<br>he atte   | by Physician/Med | in the past 12 months? 1 ☐ Yes 2 ☐ No   |  | nth 2.∏Fe<br>antattime of<br>won |                                    | ⊒Ectopic pro<br>⊒ Other (spe |                         |                          |            |  |                               | Month                         | Day Year                                       |
| P.0                                    | d by ti  | 된                | 9 Unknown   |  |                                  | aculting in the                    |                              |                         | - in Dead                |            | 225 Did to                               | -b                            | a-t-ibta ta ti                | ha assume of death?                            |
| Division of Vital Records, P.O. Box 68 | w requires that the death certifical<br>been signed by the attending phy<br>should be detached for use as th   |                  | Part II. Other significant conditions   | contributing to de                               | am out not re                    | esulting in the t                  | maenying ca                  | use give                | n in Рап I.<br>          |            | 239. Did (                               |                               |                               | he cause of death?                             |
| ဝ၁                                     | 8 8 8  | Completed        |   |  |                                  |                                    |                              |                         |                          |            | 24a. Was                                 |                               | b. Were auto                  | psy findings available<br>mpletion of cause of |
| Œ.                                     | ician: The lav<br>certificate hes<br>rector, page 2  | Com              |   |  |                                  |                                    |                              |                         |                          |            | perfo                                    | rmed?                         | death?                        |  |
| Vita                                   | ician:<br>Sertific<br>ector.   | Be               | 25. Was case referred to medical examiner?  | Hospital:  |                                  |                                    |                              | 0                       |                          | of Death   | Check only o                             | ne)                           |                               |  |
| of                                     | Physical direction   | ၉                | 1 ☐ Yes 2 ₹ No<br>27. Manner of Death   | 1 Lir  |                                  | ER/Outpatie                        |                              |                         | 4 🗀 Nu                   |            | me 5 Resid                               |                               |                               | (y)  |
| o                                      | ding<br>h.<br>After<br>funer   | ģ                | 1 Natural 5 Pending   | 28a. Date o<br>(Month                            | , Day Year)                      | Injury                             | M                            | Sc. Injury<br>Work      | ai<br>?<br>′es 2.∐l      |            | 28d. Describe I                          | iow injury oci                | corred                        |  |
| İSİ                                    | Atten<br>r deat<br>sctor:<br>by the  | Ifica            | 3 Suicide 6 Could not t   | 28e. Ptace                                       | of Injury - At                   | home, farm, st                     |                              |                         |                          |            | 28f. Location (S                         | Street and Nu                 | mber or Run                   | al Route Number,                               |
| á                                      | tal or<br>rs afte<br>sal Dire  | Certification:   | 4  Homicide determined  | buildin  | g, etc. (Spec                    | cify)                              |                              |                         |                          |            | City or Tov                              | vn, State)                    |                               |  |
|  | To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funersi Director: After this certificate hes been signed by the attending phicompletely filled in by the funeral director, page 2 should be detached for use as the | Medicai          | 29a. Certifier 1 ★ Certifying P (Check only one) 2 ★ Medical Exa  | hysician: To the<br>miner: On the ba<br>and mann | sis of examin                    | nowledge, deal<br>nation and/or ir | th occurred anvestigation,   | it the time<br>in my op | e, date an<br>inion, dea | d place, a | and due to the<br>ed at the time,        | cause(s) and<br>date and plac | manner as s<br>ce, and due to | tated.<br>o the cause(s)                       |
|  | To th<br>withir<br>To th<br>comp   | M                | 29b. Signature and title of certifier   |  |                                  |                                    | 29c                          | License                 | number                   |            |  | 29d. Date sig                 | ned (Month,                   | Day, Year)                                     |
|  |  |                  | m.S   | n  | D                                |                                    | T                            | 2005                    | 330                      | 9          | 1  | a Jugust                      | 444                           | 2007   |
|  | 15   |                  | 30. Name and address of person who  |  | . 1                              |                                    |                              | ,                       |                          |            |  | 1 -                           | 100                           |  |
|  | \  |                  | 31. Date filed Month Day, Years on  | , ,  | gistrar's Sig                    | spital                             | Elle                         | 100                     | 1, 1                     | m L        | 051                                      | 4 2                           | 147                           |  |
|  | Star<br>Registra   | re l             | AUG 1' 6"200  | A. A. S.   | S.J. J.S.                        | STORAL STORAGE                     | D)                           |                         |                          |            |  |                               |                               |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July **Physician** 30°, 2007 Amos R. Keller Jr. 7:40 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick memorial Hospital Frederick 8. Date of Birth
June 4, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 1922 **Funeral** Days 1 M 2 ☐ F 220-34-0863 85 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 'natural", or items 23a or 28a-f show dir al Examlner must be notified at Frederick Middletown MD Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21769 7102B Burkittsville Rd. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White ģ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) farmer own home permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygid Important: If item 27 is marked other in any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Amos R. Keller Sr. Daisy Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Keller (Wife) 7102B Burkittsville Rd. Middletown, MD. 21769 20a. Method of Disposition Date 20c. Location - City or Town, State 20b Place of Disposition (Name of Led netally Schematury Dodother Dylice) 1 Burial 2 □ Cremation 3 □ Removal from State Bible Church Cem | 8/3/2007 Middletown, MD 4 Donation 5 Other (Specify) uneral Savio cicent gure of 21. Sign <sup>22</sup>Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 Approximate Interval Between Onset and Death art1. Enter the disease, or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Imme to Cav e (Final disease or condition resulting in death) **Physician** Commen years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine certificate be executed that initiated events resulting in death) Last burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an page 2 s certificate | 1∐ Yes 2**.⊿**No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 the the

To the within 7

State Registrar 29b. Signature and title of certifier

300 S. Church St. Sox 20 32. pegistrar's Signature 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D43180

29d. Date signed (Month, Day, Year)

8/3/07

Division or Vital Records, P.O. Box 68760 death.

To the Hospital within 24 hours a To the Funeral D State

Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 0 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

5 Pending investigation

6 ☐ Could not be

Davison

**ORIGINAL** 

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Johns Hopkins Hospital, 600 North Wolfe Street, Baltimore

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Medical

1 Natural

2 Accident

3 Suicide

29a, Certifier

4 ☐ Homicide

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician William Louis Keller, Sr. 2007 3:05P M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12023 Keller Ave. Smithsburg Washington County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 11 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 XM 2 ☐ F Months 1930 Hours 217-28-7242 Yrs. 77 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or Items 23s or 28s-f ehow the Medical Exempler dust be notified at Maryland Washington Smithsburg 1 ☐ Yes 2 ☐ No Directo 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 12023 Keller Avenue 21783 U.S.A. Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 (ZYes 2 □ No 7-11-49
If Yes, Give Year or Dates: 8-1-69 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) St.Correction Facility Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be fill Health and Mentat H tem 27 Is marked off Be James R. Keller, Sr. Ruth Anna Smith Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Keller - wife item 27 12023 Keller Avenue Smithsburg Maryland 21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 tment of h rtent: If it niury or r 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or one 8/8/2007 Hagerstown, MD Rest Haven Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dailure. List only one cause on each line. 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 8 month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by that should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b director, page 2 s autopsy performed 1 Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ဥ 2 ER/Outpatient 3 DOA this After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QV 31 Date filed (Month Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death July 29<sup>Pay</sup> Physician 20ď7 Ruth Evelyn Keller 8:40A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Northampton Manor Nursing Home Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Apr. 6, 1919 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 220-05-6455 88 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐No Frederick MD Director Kevmar 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 10919 Haugh's Church Rd. 21757 USA Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Susan Willard Ira T. Warrenfeltz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Wilmer Keller (Husband) 10919 Haugh's Church Rd., Keymar, MD 21757 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Debatery, Crambold of orother blace d 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Methodist Cemetery 8/1/2007 Myersville, MD 5 ☐ Other (Specify) 4 □ Donation neral Service Licenses Bonard ddd B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ise on each line. Part1. Enter shock, or he the disease, or some art failure. List only Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** exebella saylor stroke /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3□ DOA 은 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes investigation after death 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b, Signature and title of co 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 202 hamo State Registrar

|                |  | ı                 | For State Registrar   | State of Ma                                   | aryland   |   | rtment<br><i>tificate</i>      |                            |  |                                     | giene<br>leg. No.   | The state of the s | i. ) .                                       |  |       |
|----------------|--|-------------------|---|---|---|---|--------------------------------|----------------------------|--|-------------------------------------|---------------------|--|--|--|-------|
|                | S  |                   | Decedent's Name (First, Middle, La  | est)  |   |   |                                |                            |  | 2. Date of Dea                      |                     | .,   | 3. Time of Death                             |  |       |
| P              | Physici  |                   | ALLAN GEORGE K  | ENZIE   |   |   |                                |                            |  | JULY                                | 27                  | 2007   | 5:50PMM                                      |  |       |
| 18 m           | /Medic<br>Examin   | - 2               | 4a. Facility Name (If not institution, give                                 |   |   |   | 4b. City, To                   | own, or Loc                | ation of Death                         |                                     | 4c. l               | County of Deat   | <u>-                                    </u> |  |       |
| LXammer        |  |                   |   |   |   |   |                                |                            |  | D                                   | OORCHESTER          |  |  |  |       |
|                |  | V.                |   |   | e (In yrs. las  | st hirthday)  | If Under 1                     | _                          |  | 8. Date of Birth                    |                     |  | nplace (State or Foreign                     |  |       |
|                | Funeral<br>Director  |                   |   | 1 【 <b>X</b> M 2 ☐ F                          | 73  | Yrs.  | Months                         |                            | ours Min.                              | JUN 17,                             | 1934                | NEW  | YORK   |  |       |
|                | and w  |                   | 10a. State 10b. County  |   | 10c. City,  | Town or Lo  | cation                         |                            |  |                                     |                     |  | 10d. Inside City Limits                      |  |       |
|                | aho  | 2                 | MD TALBO  | ,rr   | ΕΛ  | STON  |                                |                            |  |                                     |                     |  | 1 ☐ Yes 2X No                                |  |       |
|                | ith the Marylar<br>or 28e-f ahow<br>se notified at   | ect               |   |   | LIFT  |   |                                |                            |  |                                     |                     |  |  |  |       |
|                | if if  | 5                 | 10e. Street and Number  |   |   |   | 10f. Zip C                     | ode                        |  |                                     | 10g. Citiz          | en of What Co  | untry?                                       |  |       |
|                | 23a  | Funeral Director  | 27848 LE GATES  |   |   |   |                                | 21601                      |  |                                     |                     | USA  |  |  |       |
|                | de E   | ne                | 11. Marital Status  | 12. Was Decedent I<br>Armed Forces?           | Ever in U.S.  | 13. \   | Vas Decede                     | nt of Hispar               | nic Origin? (Spec<br>lexican, Puerto P | cify Yes or No-                     | 1                   | <ol> <li>Race - American Black, White</li> </ol>   |  |  |       |
| 9              | or th  | Ē                 | 1 ☐ Never Married 2 X Married   | 1 XYes 2 ☐ N<br>If Yes, Give                  | No  |   | ☐Yes X                         |                            | pecify:                                | ,                                   | 1                   |  |  |  |       |
| 8              | ours<br>"al",  | ρ                 | 3 Widowed 4 Divorced  | Year or Dates:                                |   |   | 10 163 22                      |                            | oocay.                                 |                                     |                     | Specify: WH]   | ITE  |  |       |
| 21215-0036     | 72 hours after death with the Maryland<br>"natural", or items 23a or 28e-1 ahow<br>odical Examinar must be notified at   | Completed         | 15. Decedent's E<br>(Specify only highest gr                                | ducation                                      |   | 16a. Deced  | lent's Usual                   | Occupation                 | a most of workin                       |                                     | 16b. Kir            | nd of Business/  | ndustry                                      |  |       |
| 21             | within 7   | pie               | Elementary/Secondary (0-12)   | College (1-4or 5                              | (+)   | life. L   | OO NOT use                     | retired)                   | g most of workin                       | g                                   |                     |  |  |  |       |
| 21             | d with<br>giene  | 0                 | 12  | 5   |   | SENIO   | R VICE                         | -PRES                      | IDENT                                  |                                     | IN                  | <b>VESTMEN</b>   | 1T   |  |       |
| D              | Hygi<br>other  | BeC               | 17. Father's Name (First, Middle, Last                                      | 1)  |   |   |                                | 18.                        | Mother's Name                          | (First, Middle,                     | Maiden :            | Sumame)  |  |  |       |
| an             | should be filed within a Mental Hygiene. marked other than imatic event, the M   | To B              | J. FREDERICK KEN  | ZIE   |   |   |                                |                            | RUTH W                                 | EMETT                               |                     |  |  |  |       |
| Maryland       | s 1 and 2 should be filed within 72 hours after death with the Maryla<br>Health and Mental Hygiene.<br>Item 27 is marked other than "natural", or items 23a or 28e-f ahov<br>Item are treumatic event, Ira Medical Examinar must be notified a | -                 | 19a. Informant's Name/Relationship  |   |   |   |                                | Street and I               | Number or Rural                        | Route Numbe                         | r, City or          | Town, State, Z   | ip Code)                                     |  |       |
| Z              | alth ar<br>27 is   |                   | BETTE S. KENZIE/  | WIFE  |   | 27848   | B LE G                         | ATES                       | COVE ROA                               | AD, EAS                             | TON,                | MD 216   | 501  |  |       |
| Ġ              | of Health<br>Item 27<br>other tre  |                   | 20a. Method of Disposition  |   |   | ce of Dispo   | sition (Name                   | of                         |  | ate                                 |                     | cation - City or   |  |  |       |
| ŏ              | 0 O b-   |                   | 1 ☐ Burial 2 ☐ Cremation 3 ☐  |   |   |   | natory or oth                  |                            | , omp = //                             | 20 / 2007                           |                     |  |  |  |       |
| Ë              | tent<br>tent<br>tent   |                   | 4 □Donation 5 □ Other (Speci  |   | CHES  |   |                                |                            | CTR 7/2                                |                                     |                     |  | ILLE, MD                                     |  |       |
| Baltimore,     | permit. Page<br>Department:<br>Importent; If<br>any Injury or<br>once.   |                   | 21. Signature of Funeral Service Lice                                       | MERIE   | ROF   | $\begin{array}{c c} & \stackrel{22}{F} \\ 20 \end{array}$ | ELLOWS                         | Address of<br>HEL<br>HARRI | FENBEIN<br>SON ST.                     | & NEWN<br>EASTO                     | AM F                | FUNERAL<br>ID 21601  | HOME PA                                      |  |       |
|                |  |                   | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only | nplications that caused                       | the death.  | Do not ente   | er the mode                    | of dying, su               | uch as cardiac or                      | respiratory ari                     | rest,               |  | Approximate<br>Interval Between              |  |       |
|                | Physician<br>/Medical  |                   | Immediate Cause (Final disease or condition resulting in death)             | a aleti                                       | e Mrc<br>a gonseque   | 1   |                                | ) us                       | eces                                   |                                     |                     |  | Onset and Death  Yell                        |  |       |
|                | Examiner   | ner               | ner   | iner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as  | a conseque                     | nce of):                   | 7                                      | of                                  | day                 | <u></u>  |  |  | years |
|                | The law requires that the death certificate be executed tie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit   | Examiner          | that initiated events   | c   |   |   |                                |                            |  |                                     |                     |  |  |  |       |
| oʻ             | en al  |                   | resulting in death) Last  | Due to (or as                                 | a conseque  | nce of):  |                                |                            |  |                                     |                     |  |  |  |       |
| 8760,          | ysici  | Physician/Medical |   | d   |   |   |                                |                            |  |                                     |                     |  |  |  |       |
| 9              | iffica<br>ig ph<br>as it   | ed                |   |   |   |   |                                |                            |  |                                     |                     |  |  |  |       |
| Box            | death certifica<br>attending ph<br>d for use as the  | 5                 | IF FEMALE:<br>23b. Was decedent pregnant                                    | 23c. If yes, outcome                          |   |   | Te                             |                            |  |                                     | 2                   | 3d. Date of deli   | very   |  |       |
|                | death<br>e atte  | icia              | in the past 12 months?  | 1□Live birth<br>4□Pregnant at                 |   |   | Ectopic pred<br>Other (spec    |                            |  |                                     |                     | Month  | Day Year                                     |  |       |
| P.0            | that the di<br>ed by the<br>detached   | nys               | 9 Unknown   | 9∐ Unknown                                    |   |   |                                |                            |  |                                     |                     |  |  |  |       |
|                | res that<br>signed t<br>be det   | by P              | Part II. Other significant conditions                                       | contributing to death b                       | ut not result   | ing in the ur   | nderlying cau                  | ise given in               | Part I.                                | 23e. Did to                         | bacco us            | se contribute to   | the cause of death?                          |  |       |
| ds             | uires<br>n sign  |                   |   |   |   |   |                                |                            |  | 1 □ Y                               | es 2                | 3   Pr   | obably 4 Unknown                             |  |       |
| Vital Records, | w require<br>been sig<br>should t  | Completed         |   |   |   |   |                                |                            |  | 24a. Was a                          | 20                  | 24h Were au  | topsy findings available                     |  |       |
| Re             | has<br>ge 2  | Ę.                |   |   |   |   |                                |                            |  | autop                               | sy                  | prior to death?  | completion of cause of                       |  |       |
| <u>=</u>       |  |                   |   |   |   |   |                                |                            |  |                                     | 2 <b>□</b> No       | 1 🗆 Yes  | 2 □ No                                       |  |       |
| N N            | ysicien: Th<br>is certificate<br>director, pag   | Be                | 25. Was case referred to medical examiner?                                  | Hospital:                                     |   |   |                                |                            | Place of Death                         | (Check only or                      | ne)                 |  |  |  |       |
| <del>o</del>   | di is  | ၉                 | 1 ☐ Yes 2 ☑ No  | 1 lnpatie                                     |   | P/Outpatien   |                                |                            | Nursing Hom                            |                                     |                     | · · · · · · ·  | cify)  |  |       |
|                |  | on:               | 27. Manner of Death 1 ☑Natural 5 ☐ Pending                                  | 28a. Date of Injui                            | ry<br>y Yea <i>r</i> ) 2  | 8b. Time of<br>Injury                                     |                                | c. Injury at<br>Work?      |  | 8d. Describe h                      | ow injury           | occurred   |  |  |       |
| sio            | Attending or death.  | cat               | 2 Accident investigation 3 Suicide 6 Could not be                           |   |   |   | М                              | 1 🗆 Yes                    |  |                                     |                     |  |  |  |       |
| Division       | or Attendated after death Director: in by the  | Certification:    | 4 Homicide determined   |   | ury - At hom<br>c. <i>(Specify)</i>   | e, farm, str  | eet, factory,                  | office                     | 2                                      | 8f. Location (S<br>City or Tow      |                     |  | ral Route Number,                            |  |       |
|                | To the Hospitel or Atte<br>within 24 hours after de<br>To the Funeral Directo<br>completely filled in by th  |                   |   |   |   |   |                                |                            |  |                                     |                     |  |  |  |       |
|                | To the Hospitel within 24 hours a To the Funeral completely filled   | edical            | (Check only 2 Medical Exa   | hysician: To the best ominer: On the basis of | examinatio  | edge, death<br>n and/or inv                               | occurred at<br>restigation, in | the time, d                | late and place, a<br>n, death occurre  | nd due to the o<br>d at the time, o | ause(s)<br>date and | and manner as<br>place, and due  | stated.<br>to the cause(s)                   |  |       |
|                | the<br>the<br>nplet  | Med               | one)  | and manner sta                                | rreid.  |   |                                |                            |  |                                     |                     |  |  |  |       |
|                | o T vill   |                   | 29b. Signature and title of certifier                                       | 4 //  |   |   | 29c.                           | License nur                | O 7                                    | > 1                                 | eso. Date           | signed (Month  | n, Day, Year)                                |  |       |
| •              |  |                   | MILIA   | Mha   | ~   |   | 1                              | 12                         | 1 14                                   |                                     | 11                  | 28/07  | >  |  |       |
|                | 2+VA   |                   | 30. Name and address of person who  |   |   |   | ,                              | ATTOD                      | RIIRY MD                               | 2100/                               |                     | ( )  |  |  |       |
|                |  |                   | MILLIAN RUBING  | IVI II I 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1      | 1111/   | 3 I I IIV   |                                | MI. I 3 P                  | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1  | / 1 0 1 4                           |                     |  |  |  |       |

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) JUL 3 0 2007

. Registrar's Signature

07-05927 Tuga Luckett

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| uga Luckett  | State of Maryland / Department of Health and Mid<br>1- For State Certificate of Death  | V 11119 V 5 5 5 5 5  |
|--|--|--|
| Physician/   | Registrar  | Reg. No.  2. Date of Death  3. Time of Death   |
| ######################################   |  | Month Day Year 1930 hrs  |
|  | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Locati  |  |
| *  | 7310 Lanham lane Ft. Washington  | Prince George's  |
| Funeral  |  | Under 24Hrs. 8, Date of Birth(MM/DD/YYYYY) 9. Birthplace (State or Foreign                           |
| Director   | 223-33-3665 1 M 2XF 36 Yrs. Months Days Ho   | ours Min. 12/04/1970 Foreign Country Maryland  |
| en tres estatuan montaggia esta estat.   | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  | 10d. Inside City Limits  |
| w any  |  | 1 Yes 2 X No   |
| Maryland<br>28a-f show<br>d at once.<br>ector  | Maryland   Prince George's   Ft. Washington   106, Street and Number   106, Zip Code   | 10g. Citizen of What Country?  |
| the Maryland<br>a or 28a-f sh<br>tiffed at once<br>Director  |  |  |
| vith th  | 7310 Lanham Lane 20744 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic   | United States Origin? ( Specify Yes or No-   |
| or death with so or items 23. const be no  | 1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexi  |  |
| safter d   |  | city: Specify: Black   |
| natura<br>xami   | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (G during most of working life. DO N  | Sive kind of work done 16b. Kind of Business/Industry  |
| n 72 h<br>n 72 h<br>isal "r<br>ical F  | Elementary/Secondary (0-12) College (1-4 or 5+)  |  |
| withi<br>within  | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  Web Page Designe  17. Father's Name (First, Middle, Last)  18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occupation (6 during most of working life. DO No. 18. Decedent's Usual Occup | r   Communication  |
| 215-<br>be filed<br>ntal Hy<br>rked of<br>ent, the   |  | orine Taylor   |
| 212<br>tould be<br>d Ment<br>d Ment<br>is marri-<br>tric ever  | O 19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and  | Number or Rural Route Number, City or Town, State, Zip Code)   |
| MD<br>12 she<br>12 she<br>127 is<br>umat   | Florine T. Brown/Mother 45557 Boyne Ct.  | Great Mills, Maryland 20634  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic eyent, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director   | 20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery crematory or other place)   | 7, Date 20c. Location - City or Town, State  |
| mo<br>Pages<br>nent or<br>ant: J   | 4 Donation 5 Other Specify: St. Mark's UAME Ceme   | t. 08/11/2007 Valley Lee, Maryland   |
| Balti<br>permit<br>Departi<br>Import   | 21. Signature of Funeral Service Licensee 22. Name and Address of Fa   | cility Brinsfield Funeral Home, P.A.   |
|  | Kyle S. Simons M01206 22955 Hollywo  | ood Rd. Leonardtown, MD 20650 as cardiac or respiratory arrest, shock, or heart Approximate Interval |
| Physician<br>√Medical  | failure. List only one cause on each line.   | Between Onset and Death  |
| xaminer  | Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  | - Journ  |
|  | Sequentially list conditions, b  |  |
| 100 Der  | if any, leading to immediate Due to (or as a consequence of):  | Y I  |
| ted Insit  | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):   |  |
| cuted nd ransit  | d  |  |
| 60, ate be execu ohysician and burial - tra  | UNPENDED AMENDED   |  |
| 760, icate be physicate the buricate hard  |  | 23d. Date of delivery  |
| certif   | past 12 months?  1 Live birth 2 Fetal death 3 Eco  | topic pregnancy Month Day Year   |
| Box<br>death<br>he atte  | 23b. Was decedent pregnant in the past 12 months?  1   |  |
| O. — nat the cid by t  |  |  |
| ires the case of t | Pg   | 1 Yes 2 No 3 Probably 4 Unknown  |
| ords   |  | 24a. Was an autopsy prior to completion of cause of  |
| Reco   | Completed  | performed? death?  1  Yes 2 No 1  Yes 2 No   |
| ian: J   | o 25. Was case referred to medical 26.Place of De  | eath (Check only one)  |
| Physic Physic al dire  | O 1 V Yes 2 No Inpatient 2 ER/Outpatient 3 DOA   |  |
| Division of Vital Records, P.O. Box 687 and or Attending Physician: The law requires that the death certific rall birrector: After this certificate has been signed by the attending I led in by the funeral director, page 2 should be detached for use as the refiferation: To Be Committed by Physician/  |  | Work? 28d. Describe how injury occurred Subject shot   |
| Sion<br>Attend<br>r death.<br>ector:<br>by the f   | 2 Accident Investigation   28e. Place of Injury - At home, farm, street, factory, office building  |  |
| Divi   | Suicide Could not be determined (Specific) Single Family   | or Town, State) 7310 Lanahm Lane, Ft. Washington, Md.  |
| Hospi<br>4 hou<br>Funer<br>ely fil   | 1 298. Certifier   |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition or To Re Commleted by Physician/Medical Ex   | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea and manner stated.  29b. Signature and title of certifier 29c. License num   | th occurred at the time, date and place, and due to the cause(s)                                     |
| F S F S  | 29b. Signature and title of certifier 29c. License nun   | nber 29d. Date signed (Month, Day, Year)   |
| J.   | O.C.M.E.   | August 3, 2007   |
| 9  | 30. Name and address of person who completed cause of death (Item 23a)   | AND 04004  |
| \  | Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, 112 31. Date filed (No. 2007) Assistant Medical Examiner 111 Penn Street, Baltimore, 112 31. Date filed (No. 2007) Assistant Medical Examiner 111 Penn Street, Baltimore, 112 31. Date filed (No. 2007) Assistant Medical Examiner 111 Penn Street, Baltimore, 112 31. Date filed (No. 2007) Assistant Medical Examiner 111 Penn Street, Baltimore, 112 31. Date filed (No. 2007) Assistant Medical Examiner 111 Penn Street, Baltimore, 112 31. Date filed (No. 2007) Assistant Medical Examiner 111 Penn Street, Baltimore, 112 31. Date filed (No. 2007) Assistant Medical Examiner 112 Penn Street, Baltimore, 112 31. Date filed (No. 2007) Assistant Medical Examiner 112 Penn Street, Baltimore, 112 31. Date filed (No. 2007) Assistant Medical Examiner 112 Penn Street, Baltimore, 112 31. Date filed (No. 2007) Assistant Medical Examiner 112 Penn Street, Baltimore, 112 31. Date filed (No. 2007) Assistant Medical Examiner 112 Assistant Me | V  |
| Stat<br>Registra   | AUG U O ZUU! Ma  |  |
|  |  |  |

State of Maryland / Department of Health and Mental Hygiene

|                     |   |                 |   | Otate   | i wai yiai                      |                         | •           |                      | Death                       | wentar ny                            | Reg. No.              | 07          | 26395   |
|---------------------|---|-----------------|---|---|---------------------------------|-------------------------|-------------|----------------------|-----------------------------|--------------------------------------|-----------------------|-------------|---|
|                     | DI :  |                 | 1. Decedent's Name (First, Mic  |   |                                 | eeth<br>Dey Year        |             | 3. Time of Death     |                             |                                      |                       |             |   |
| · mile              | Physic<br>/Medi   |                 | ROBERT CLAUDE   | LOWERY  |                                 |                         |             |                      |                             | AUGUS'                               |                       | 2007        | 9:25 AM   |
|                     | Exami   |                 | 4a Fecility Neme (If not institut   | tion, give street end nur                                       | n <i>ber)</i>                   |                         |             |                      | 4b. City, Town, o           | r Location of Dee                    | th 4c. County         | of Death    |   |
|                     |   |                 | 106 BENTONS PI  |   |                                 |                         |             |                      | CHESTER                     |                                      | QUEEN                 |             |   |
|                     | Funeral   |                 | 5. Social Security Number   | 6. Sex<br>1 <b>X</b> M 2 □ F                                    | 7. Age (In yrs.                 | lest birthda<br>Yrs.    | Month       | der 1 Year<br>s Days | If Under 24 Hr<br>Hours Mir | . (Month, D                          | rth<br>ay, Year)      | 9. Birthp   | place (State or Foreign ntry)                                 |
|                     | Director  |                 | 217-28-3621 Usuel Residence of Decedent   |   | 75                              | 113.                    |             |                      |                             | JANUARY                              | 20, 1932              | MAR         | RYLAND  |
|                     | and Hand  |                 | 10a. State 10b. Cour  | nty   | 10c. Ci                         | ty, Town or             | Location    |                      |                             |                                      |                       | 1           | 0d. Inside City Limits  |
|                     | with the Marylan<br>s or 28a-f show<br>the notified at  | to              | MARYLAND QUEER  | N ANNE'S  | СН                              | ESTER                   |             |                      |                             |                                      |                       |             | 1 ☐ Yes 2 🙀 No  |
|                     | 1 the   | Director        | 10e. Street end Number  |   |                                 |                         | 10f. 2      | Zip Code             |                             |                                      | 10g. Citizen of \     | What Coun   | itry?   |
|                     | 23e c   |                 | 106 BENTONS PI  | LEASURE ROA   | D                               |                         | 21          | 1619                 |                             |                                      | UNITED :              | STATE       | S   |
|                     | Heme<br>Heme  | Funeral         | 11. Merital Status  | 12. Was Dece<br>Armed Fo  | dent Ever in U                  | I,S. 13                 |             |                      | lispanic Origin? (          | Specify Yes or N<br>rto Rican, etc.) |                       | e - Americ  | an Indian,  |
| 21215-0020          | To bE   | ð               | 1 □ Never Married 2 <b>X</b> M<br>3 □ Widowed 4 □ Divorc  | arried 1 ☐ Yes  | 2 No                            |                         |             |                      | Specify:                    |                                      |                       | WHI         |   |
| 5-0                 | 72 hours<br>'natural',<br>dical Exe   | Completed       |   | ent's Education<br>hest grade completed)                        |                                 | 16a. Dec                | cedent's Us | sual Occup           | ation<br>during most of w   | orkina                               | 16b. Kind of B        | usiness/Inc | Justry  |
| 21                  | within<br>ena.<br>then  | d               | Elementary/Secondary (0-12  |   | -4or 5+)                        |                         |             |                      | during most of we           |                                      |                       |             |   |
| 2                   | 77 75 16 18   |                 | 11  |   |                                 | FISE                    | IERMAI      | 1                    | 40.14.4.1.44                | /F1                                  | WATERMA               |             |   |
| anc                 | be file<br>ad othe<br>event,  | B               | 17. Father's Neme (First, Middle  |   |                                 |                         |             |                      |                             |                                      | e, Maiden Surnan      | 10)         |   |
| ž                   | d Mer<br>d Mer<br>marks   | Ç               | WILLIAM COOK I  |   |                                 | 40h 14-                 | . 101       | (0)                  |                             | COUNCII                              |                       | 0 7         | 0-4-)   |
| Ma                  | d 2 s<br>th an<br>7 is r  |                 | 19a. Informant's Name/Relatio   |   |                                 |                         | _           |                      |                             |                                      | er, City or Town,     |             |   |
| ē,                  | ges 1 end 2 should be filed<br>it of Health and Mental Hyg<br>if Item 27 is marked othe<br>or other traumatic event,  |                 | 20a. Method of Disposition  | EKI/WIPE  |                                 | Place of Dis            | position (A | ame of               |                             | Date                                 | 20c. Location -       |             | AND 21619<br>own, State                                       |
| Baltimore, Maryland |   |                 | 1 ☐ Burial 2 🗶 Cremetion 4 ☐ Donetion 5 ☐ Other   |   | State                           | cemetery, cr            |             |                      |                             | AUGUST 2                             |                       |             |   |
| ≣                   | Demit. Pa<br>Depertment<br>Important:<br>any Injury   |                 | 21. Signature of Funetal Service  |   | CHI                             | ESAPEA                  | 22. Name    | and Addres           | ss of Facility              | 2007                                 | -                     |             | , MARYLAND  |
| ä                   | Deper<br>Impo   |                 | - (ARIÈ)  | * the   | ) mor                           |                         |             |                      |                             |                                      | WNAM FUR<br>R, MARYLA |             | HOME, P.A.<br>1619  |
|                     |   |                 | 23a. Part1. Enter the disease, shock, or heart failure. Li  | or complications that ca<br>ist only one sauss on ea            | aused the deet<br>ach line.     |                         |             |                      |                             |                                      |                       |             | Approximate<br>Interval Between                               |
|                     | Physician<br>/Medical   |                 | Immediate Course (Final   | 1000  | 1 +                             | +                       | 10          | 2.7                  | 1.0.                        | .00                                  | ancer                 | į<br>į      | Onset and Death   |
|                     | Examiner  |                 | Immediate Cause (Final<br>disease or condition<br>resulting in death)   | · Me  | tus 1.                          | a 110                   | VV          | Wr                   | nu c                        | ec c                                 | encer                 |             | 2 weeks   |
|                     |   | -               |   |   | Due to (d                       | or as a cons            | equence o   | f):                  |                             |                                      |                       | !           |   |
|                     | uted<br>ansit   | 튙               |   | b   | Due to (s                       | or as a cons            |             | ٨.                   |                             |                                      |                       | i           |   |
| Ć.                  | axec<br>tn en<br>nel-tr   | Exa             | if eny, leading to immediate cause. Enter Underlying  | 1   | Due to (c                       | n as a cons             | equence o   | 1).                  |                             |                                      |                       | 1           |   |
| 68760,              | tificate ba axecuted ig physician end es tha buriel-trensit   | edical Examiner | Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | C   | Due to (c                       | r as a cons             | equence of  | n:                   |                             |                                      |                       |             |   |
|                     | ntifica<br>ng ph<br>es th   |                 | resulting in death) Last  |   | ·                               |                         |             | ,                    |                             |                                      |                       | i<br>I      |   |
| Box                 | th cer<br>tendir<br>r use   | an              |   | d   |                                 |                         |             |                      |                             |                                      |                       | 1           |   |
|                     | The law requires that the deeth cer<br>ate has been signed by the ettendir<br>pega 2 should be detached for use   | Physician/M     | Part II. Other significent condi  | tions contributing to de  | eth but not res                 | ulting in the           | underlying  | cause give           | en in Part I.               | 23b. <b>Did</b>                      | tobacco use go        | ntribute to | the cause of death?   |
| Р.<br>О.            | at the  | F.              |   |   |                                 |                         |             |                      |                             | 1 🗆                                  | Yes 2 No              | 3 Prob      | oably 4 ☐ Unknown   |
| Ś                   | igner<br>bed  | 6               |   |   |                                 |                         |             |                      |                             |                                      |                       |             |   |
| 9                   | v raquire<br>baan sig<br>should b   | E E             |   |   |                                 |                         |             |                      |                             | 24a. Was                             | an autopsy ormed?     | ava         | ere autopsy findings<br>ailable prior to<br>mpletion of cause |
| Records,            | law<br>lasb<br>a 2 sl   | Completed       |   |   |                                 |                         |             |                      |                             |                                      |                       | of c        | death?  |
| <u>~</u>            | cate t  |                 |   |   |                                 |                         |             |                      |                             | 40                                   | Yes 2000              | 1           | ]Yes 2□No   |
| <u>₹</u>            | clan<br>Sertifi<br>Sector   | Be              | 25. Was case referred to medic examiner?  | Hospital:   |                                 |                         |             | Othe                 | or:                         | eath (Check only                     | one)                  |             | -   |
| ō                   | Physical directions of the direction of | <u>1</u>        | 1 Yes 2 No 27. Magner of Death  | 1 Ulr   |                                 | ER/Outpati<br>28b. Time |             | JON !                | 4 Li Nursing                | -                                    | idence 6 Oth          |             | )   |
| 5                   | After fune  |                 | Natural 5 ☐ Pend  | ling (Month   | f Injury<br>h, <i>Day Year)</i> | Injury                  |             | 28c. Injury<br>Work  | k?<br>Yes 2□No              | 200. 9030100                         | now injury occur      | 90          |   |
| Division of Vital   | Attending Physician: r death. sector: After this certific by the funerel director.  | flea            | 3 ☐ Suicide 6 ☐ Coul  | d not be  | of Injury - At he               | ome, farm, s            |             |                      |                             | 28f. Location                        | Street and Numb       | er or Rura  | l Route Number,   |
|                     | affer<br>Direction by din by  | Certification:  | 4 Homicide  | buildin   | g, etc. (Specif                 | y)                      | ,           |                      |                             | City or To                           | wn, State)            |             |   |
|                     | Yo the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  | edical C        |   | ring Physician: To the la<br>al Examiner: On the ba<br>and mann | sis of examina                  |                         |             |                      |                             |                                      |                       |             |   |
|                     | thin of the complete  | Me              | 29b. Signature and title of certif  |   | -                               |                         | 2           | 9c. License          | number                      | 7                                    | 29d. Date signe       | d (Month, L | Day, Year)  |
|                     | m   |                 | > XT.   | D/M   | ~                               |                         |             | 1)                   | 2670                        | 15                                   | 8/1                   | 100         | 7   |
| -                   | m /   |                 | 30. Name and address of perso   | n who completed cause   | of death (Item                  | 1 23e) (Type            | e, Print)   | -                    |                             |                                      | - 1 - 1               | -           |   |
| -                   | 5)  |                 | HOWARD GOLDSTE  |   |                                 |                         |             | ITE 4                | 00, ANNA                    | POLIS. 1                             | MARYLAND              | 2140        | 1   |
|                     | Sta   | re.             | 31. Date filed (Month, Day, Yea   |   | etrar's Signa                   |                         | 1           | est a                |                             | -                                    |                       |             |   |

DHMH 16 Rev 6/95

| L                              | Directo  |
|--------------------------------|--|
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at |
|                                | Physician<br>/Medica<br>Examine  |
|                                |  |

1. Decedent's Name (First, Middle, Last)

|  |  | 1. Decedent's Name (First, Middle, Last)   |  | 2. Date of Death<br>Month                   | Day Year  | 3. Time of Death                             |  |  |  |  |  |  |  |  |
|--|--|--|--|---|---|--|--|--|--|--|--|--|--|--|
| /siciar<br>ledica  |  | Barbara Ann Liles  |  | July 2                                      | 8, 2007   | 2300 P™                                      |  |  |  |  |  |  |  |  |
| amine  |  | 4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital   | 4b. City, Town, or Location of Death Takoma Park   |   | ac. County of Death                                     | У  |  |  |  |  |  |  |  |  |
| eral<br>etor   |  | 5. Social Security Number 6. Sex 1. Age (In yrs. last birthday) 6. The second of the | If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.   | 8. Date of Birth (Month, Day, Yes 10/06/1   | 9. Birthpl<br>Count<br>945 Wash                         | ace (State or Foreign<br>try)<br>ingt On DC  |  |  |  |  |  |  |  |  |
| thed at  | 5  | Usual Residence of Decedent  10a. State  |  |   | 10  | 0d. Inside City Limits 1X Yes 2 □ No         |  |  |  |  |  |  |  |  |
| ust be notified  |  | 10e. Street and Number 11603 Chantilly Lane  | 10f. Zip Code<br>20721   |   | Citizen of What Count<br>SA                             | try?   |  |  |  |  |  |  |  |  |
| one.  To Bo Completed by Europeal Director  To Bo Completed by Europeal Director | 2  | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No   | as Decedent of Hispanic Origin? (Sp<br>Yes, specify Cuban, Mexican, Puerto<br>□ Yes 🌠 No Specify:  | ecify Yes or No-<br>Rican, <i>e</i> tc.)    | 14. Race - America<br>Black, White, e<br>Specify: Blace | etc.   |  |  |  |  |  |  |  |  |
| Completed  | Inpicio  | (Specify only highest grade completed) (Give kilfe. Die Elementary/Secondary (0-12) College (1-4or 5+)   | nt's Usual Occupation<br>ind of work done during most of work<br>O NOT use retired)  | ing   | Kind of Business/Ind                                    | ustry  |  |  |  |  |  |  |  |  |
| Bo   | 3  | 17. Father's Name (First, Middle, Last)  John E. Williams  | NEA<br>e (First, Middle, Maid<br>Jamis   | len Surname)                                |   |  |  |  |  |  |  |  |  |  |
| Ę  | 2  | 19a. Informant's Name/Relationship (Type. Print) aughter 19b. Mailing  | Barbara Address (Street and Number or Rur Chantilly Lar  | al Route Number, Cit                        | y or Town, State, Zip                                   |  |  |  |  |  |  |  |  |  |
|  | Ì  | 20a. Method of Disposition  1 Network 2 Communication 3 Removal from State  20b. Place of Disposition cemetery, crem.  | Date 20c.  | Location - City or To                       | wn, State   |  |  |  |  |  |  |  |  |  |
| ouce.  |  |  |  |   |   |  |  |  |  |  |  |  |  |  |
| an<br>al   | 23a. Fert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of): |  |  |   |   |  |  |  |  |  |  |  |  |  |
| ian/Modical Evaminor   |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):   | REMAR DISC   | £AS€  |   |  |  |  |  |  |  |  |  |  |
| Dhysician/Medical  |  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ III □ Yes 2 □ No 9 □ Unknown   | Ectopic pregnancy<br>Other (specify)   |   | 23d. Date of delive<br>Month                            | ry<br>Day Year                               |  |  |  |  |  |  |  |  |
| Jd yd be   | 2  | Part II. Other significant conditions contributing to death but not resulting in the unc   | lerlying cause given in Part I.  |   | o use contribute to th                                  | e cause of death?<br>ably 4 □Unknown         |  |  |  |  |  |  |  |  |
| Completed  | and in on  | CEREBROVASCULAR ACC  | DEreī  | 24a. Was an autopsy performed′<br>1 Yes 2 ☑ | prior to con<br>death?                                  | osy findings available inpletion of cause of |  |  |  |  |  |  |  |  |
| Bo   |  | 25. Was case referred to medical examiner?   |  | h (Check only one)                          | '   |  |  |  |  |  |  |  |  |  |
| F. uci   | 2  | 1  | 28c. Injury at<br>Work?  | ome 5 Residence<br>28d. Describe how in     | 6 ☐Other (Specify<br>njury occurred                     | )  |  |  |  |  |  |  |  |  |
| Certification.   | 100  | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, streed building, etc. (Specify)   | M 1 ☐ Yes 2 ☐ No et, factory, office   | 28f. Location (Street<br>City or Town, St   | and Number or Rura<br>ate)                              | l Route Number,                              |  |  |  |  |  |  |  |  |
| adical Cartification: To Be Completed by Physic                                  | Bollon   |  | ertifier  1 S Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the carbeck only  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, d |   |   |  |  |  |  |  |  |  |  |  |

Division or Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Month, Day, Year AUG 0 1 2007

ne and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per dyr 870 8-16-07 each and Mental Hygiene
State of Maryland Bepartment of Health and Mental Hygiene State Registrar amended item #4/wchd/map 8-Gertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** ANKFORT ((:42 28 /Medical Truck 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE HOSPITAL 177 JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Secial 8 Security Number -50-2150 Months Days Hours Min. 1 □ M 2 🖫 F Director Maryland -30 - 21308/15/1949 Usual Residence of Decedent the Maryland 10c. City, Town or Location r 28a-f show notified at 10a State 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 6 the Medical Examiner must be 21804 Items 23a 506 Dover St. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status e filed within 72 hours after dail Hygiene.

other than "natural", or item 1 ★ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No ģ Specify. 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Customer Service Rep 12 Banking permit. Pages 1 and 2 should be filed Department of Heatth and Mental Hyg Important: If item 27 Is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Lankford Betty L. Phippin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty Lankford/mother 506 Dover St., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Wicomico Memorial Park 8/2/07 Salisbury, MD 21. Signature of Funeral Service Licens

**Physician** /Medical

> the be detached

peen

has

this

24 hours after death. Funeral Director: After

To the I within 2

filled in by the funeral

P.O. Box 68760 death certificate be

Division or Vital Records,

Attending Physician:

Hospital or

**Examiner** Examiner attending physician and for use as the burial-tran

Parl. Enter the disease, or complications to ck, or heart failure. List only one cause liate Cause (Final Imm diate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): THROMBOEMBOLIS ) ENOUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) PULMONARY Due to (or as a consequence of):

Approximate Interval Between Onset and Death

HOURS

24

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown

Physician/Medical

2

Completed

Be

2

Certification:

Medical

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9□ Unknown

3 Ectopic pregnancy 5 Other (specify)

that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line.

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

1 🔲 Yes 2**X**No

3 ☐ Probably 4 ☐ Unknown

1287

24a. Was an autopsy 1□ Yes

Professional Association Home Professional Association

501 Snow Hill Rd., Salisbury, MD 21804

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? Hospital: 1 Yes 2X No 1 Dipatient 27. Manner of Death

5 Pending investigation

6 Could not be

determined

2 ER/Outpatient Date of Injury (Month, Day Year) 28a. Date 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 🗌 Yes 2 ∏No . Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3□ DOA

28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 X Natural

2 Accident

3 ☐ Suicide

4 Homicide

Certifying Shysidien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the er: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signatu and title of c rtifi

MEDICAL DOCTOR

000

29d. Date signed (Month, Day, Year) 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LIBRISK 31. Date filed (Month, Da)

600 MURTEL 32. Registrar's Signature

STREET

State Registrar 07-06081 Mary Lutz Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| ,      |   |   |                | For State  |  | Cert                               | ificate of       | Death                            |              |              |                                | eg. No.                       | 1.              |  |
|--------|---|---|----------------|--|--|------------------------------------|------------------|----------------------------------|--------------|--------------|--------------------------------|-------------------------------|-----------------|--|
| ***    | Phys  | iciai   | 1/ 1           | Acceptable   Company   C |  |                                    |                  |                                  |              |              |                                |                               |                 | 3. Time of Death<br>0625 hrs                     |
|        | TI LAG  |   |                | a. Facility Name (if not institution   |  |                                    |                  | -                                |              | of Death     |                                | 4c. County of                 |                 |  |
|        |   |   |                | 224 East 7th Street  |  | I = 7                              | LL: thatas N     | Frederick                        |              | der 24Hrs.   | 8 Date of Bi                   | rth (MM/DD/YYYY               |                 | place (State or                                  |
|        | Funer<br>Direct   |   |                | Social Security Number 273-52-9171   | 6. Sex                                   | 7. Age (In yrs. las                |                  | Months [                         | Days Hou     |              | 1                              | 18, 195                       | Foreign         | ntry) Ohio                                       |
|        |   | ,   | -              | Isual Residence of Decedent  Oa. State 10b. County   |  | 10c. City.                         | Town or Locati   | on                               |              |              |                                |                               | 7               | 10d. Inside City Limits                          |
|        | d<br>bow any  |   | - 1            | Maryland Fred  |  |                                    | erick            |                                  |              |              |                                |                               |                 | 1 X Yes 2 No                                     |
| -      | , MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland and 1 should be filed within 72 hours after death with the Maryland 71: | fied at once  |                | 0e. Street and Number<br>224 East 7th S  | Street                                   |                                    |                  | 10f. Zip Coo                     | 1701         |              | -7 1                           | 10g. Citizen of W             |                 | ry?  |
|        | ath with th   | st be noti  |                | Marital Status     Never Married 2X N  | Married Armed                            |                                    |                  | s Decedent o<br>es, specify C    |              |              | ecify Yes or N<br>Rican, etc.) |                               | e, etc.         | an Indian, Black,                                |
|        | ter de  | er mu   |                | 3 Widowed 4 Di   | 1 Yes                                    | 2 X No                             | 1                | Yes 2X                           | No speci     |              |                                | Specify:                      |                 | ite  |
|        | ours af   | camin   | d by           | 15. Decedent's Education (Sp.  | ecify only highest gr                    | ade completed)                     | 16a. Deceder     | it's Usual Occ<br>ost of working | upation (Giv | e kind of w  | ork done<br>ed)                | 16b. Kind of B                | usiness/lr      | ndustry  |
| (      | <b>6</b><br>172 nc  | Cal E   | lete           | Elementary/Secondary (0-12 1 2   | ) College                                | (1-4 or 5+)                        | · ·              | etail                            |              |              |                                | Food                          | Indu            | strv   |
| 600    | within giene.   | Med   | Comple         | 1 ∠<br>17. Father's Name (First, Middle  | e Last)                                  |                                    |                  | e cair.                          |              | _            | (First, Middle                 | Maiden Surname                |                 | 301)   |
| 3      | 215-0036<br>be filed within 7<br>ntal Hygiene.  | nt, the   | αl             | Charles John (   |  |                                    |                  |                                  |              |              | Maria N                        |                               |                 |  |
| 3      | ID 21215-0036 should be filed within 72 hours after and Mental Hygiene.   | s mar   | 라              | 19a. Informant's Name/Relation   |  |                                    |                  |                                  |              |              |                                | inber, City or To             |                 |  |
| :      | MD and and and and and  | tem 2/ IS n<br>traumatic  | L              | Carl T. Lutz   | Husband                                  | 20h F                              | Place of Dispos  |                                  |              |              | Date                           | ick, Mar                      |                 |  |
|        | <b>⊎</b> _ ≖ :  | other traums  | 1              | 20a. Method of Disposition  1 Burial 2 X Cremation   | on 3 Removal                             | from Choice                        | crematory or of  | her place)                       |              |              | /07                            | Smiths                        | burg            | , Maryland                                       |
| ;      | timor<br>t. Pages<br>rtment of  | rtant:<br>y or o  | -  -           | 4 Donation 5 Other 21. Signature of Funeral Service  | Specify:                                 | 7)                                 |                  |                                  |              |              |                                | JNERAL H                      |                 |  |
| ſ      | Ba<br>perm<br>Depa  | injury  |                | d/l-fr   | JAN I                                    | ent!                               | 112              | O1 NOR                           | TH MA        | RKET         | ST., FI                        | REDERICK                      | . MD            | 21701  |
| at No. | Physic  |   | T              | 23a. Part I. Enter the disease, failure List only one caus   | or complications that<br>se on each line | caused the death.                  | . Do not enter   | the mode of d                    | ying, such a | s cardiac o  | or respiratory a               | ırrest, shock, or h           | eart            | Approximate Interval Between Onset and Death     |
|        | Medi<br>ami،  |   | 11             | Immediate Cause (Final diseas  | se a Amitri                              | tyline int                         |                  | n                                |              |              |                                |                               |                 | Death  |
|        |   |   |                | or condition resulting in death)   | b.                                       | s a consequence o                  | 1):              |                                  |              |              | h .                            |                               |                 |  |
|        |   |   | ner            | Sequentially list conditions,<br>if any, leading to immediate<br>cause. Enter Underlying Cause   |  | s a consequence o                  | f):              |                                  |              |              |                                |                               |                 | j l  |
|        |   |   | Examine        | (Disease or injury trial initiated events resulting in death) Las  | Due to (or o                             | s a consequence o                  | of):             |                                  |              |              |                                |                               |                 |  |
|        | cuted   | and<br>- transit  |                |  | d  |                                    |                  |                                  |              |              |                                |                               |                 |  |
|        | 5   | physician and the burial -  | Medical        | X UNPENDED   | #ZSa,                                    | 27,28a-f, p                        | erME,g87         | 71, 915/0                        | <u> </u>     |              |                                | 23d. Date                     | of deliver      | V  |
|        | 8760,<br>ifficate be  | ng phy:<br>as the b   |                | IF FEMALE:<br>23b. Was decedent pregnant in<br>past 12 months?   | the 1 Liv                                | s, outcome of preg<br>e birth      | 2 F              | etal death                       | 3Ec          | topic pregn  | ancy                           | Month                         |                 | Day Year   |
|        | Division of Vital Records, P.O. Box 68' ral or Attending Physician: The law requires that the death certifins after death.                                  | e attending  <br>for use as t   | Physician      | 1 Yes 2 No 9 🗸   |  | egnant at time of de<br>known      | eath 5 C         | Other (Specify                   | )            |              |                                |                               |                 |  |
|        | the de  | by the  | Phy            | Part II. Other significant con-  |  |                                    | resulting in the | underlying ca                    | ause given i | n Part I.    |                                |                               |                 | the cause of death?                              |
|        | P.C   | s been signed by the<br>should be detached  | d by           |  |  |                                    |                  |                                  |              |              | 1                              | 125-25                        |                 | bably 4 Unknown                                  |
|        | rds,<br>requir  | peen s  | Completed      | ,  |  |                                    |                  |                                  |              |              |                                | topsy                         | prior to        | utopsy findings available completion of cause of |
|        | eco<br>he law   | 2 2   | dwo            |  |  |                                    | -                |                                  |              |              |                                | rformed?                      | death?<br>1 ✓ Y | es 2 No  |
|        | <u>&amp;</u>  | certificate<br>ector, page  | 0              | 25. Was case referred to med   |  |                                    |                  | 26                               | Place of De  |              |                                |                               |                 |  |
|        | Vita  | this call direct  | To B           | examiner?  1 ✓ Yes 2 No  | Hospital: 1                              | Inpatient 2                        | ER/Outpatie      |                                  | Othe         | 7            | ing Home 5                     | Residence 6                   |                 | er: Scene  |
|        | 1 of<br>Jing P  | After<br>funera   |                | 27. Manner of Death  1 Natural 5 P   |  | ate of Injury<br>onth, Day,Year)   | 28b. Time o      | '                                | 1 Yes        |              | unk                            | 50 11511 111,511, 511         |                 |  |
|        | SiOI<br>Attend  | ector:<br>by the  | icati          | 2 Accident In  | ivestigation 28e F                       | 8/4/2007<br>Place of Injury - At I | Fnd 6:           | L/pm                             |              |              |                                |                               | mber or F       | tural Route Number, City                         |
|        | Divis   | al Dir  | Certification: |  | ould not be<br>etermined (Spec           |                                    | d at res         |                                  |              |              | 224 E.                         | n, State)<br>7 <b>th</b> St。] | Frede           | rick, MD   |
|        | Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certifunitin 24 hours after death.         | To the Funeral Director: After this certificate to completely filled in by the funeral director, page |                | 29a. Certifier 1 Certifying  | Physician: To the<br>xaminer:On the ba   | best of my knowle                  | dge, death occ   | curred at the t                  | me, date ar  | nd place, ar | nd due to the d                | ause(s) and man               | ner as sta      | ated.<br>the cause(s)                            |
|        | To the  | To the  | Medical        | 2  | and mann                                 | er stated.                         | and/or investig  |                                  | License nur  |              | at the time, a                 |                               |                 | lonth, Day, Year)                                |
| Ø      |   |   | Ž              | 29b. Signature and title of cer  | 1 L I                                    | 77 (                               | _                |                                  | O.C.M.E      |              |                                | August 8                      |                 |  |
|        |   |   |                | 30. Name and address of per  | son who completed                        | cause of death (Ite                | m 23a)           |                                  |              |              |                                |                               |                 |  |
|        |   |   |                | ov. Name and address or per  | Con mino completed                       |                                    | ,                |                                  |              |              |                                |                               |                 |  |
|        |   |   |                | Zabiullah Ali, M.D.  |  | dical Examine                      |                  | enn Street                       | , Baltimo    | re, MD 2     | 21201                          |                               |                 |  |

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** EVELYN L. LANG 6:30AM M JULY 27 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT HOSPICE HOUSE EASTON TALBOT If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Hours Months Days 1 □ M 2 K F 93 MAY 11,1914 060-01-8237 NEW YÖRK Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1XYes 2 No Director MD TALBOT EASTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 304 S. AURORA ST. 21601 USA "natural", or items 23a 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify. 2 Specify: WHITE 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 HOMEMAKER OWN HOME Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES HENRY DUERRE KATHERINE WEILMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra EVELYN DUERRE VOGEL/DAUGHTER 304 S. AURORA ST., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY: 7/31/2007 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 S. HARRISON ST., EASTON, MD 21601 HOME PA JOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 years /Medical Examiner Ventribula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 □Unknown Completed Block and Permanent Palemeker 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2. No death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c, License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJASINGH, 522 IDLEWILD AVE, EASTON, MD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Augus + **Physician** Year Paul Eugene McCarty 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 <del>∏</del> M 2□ F Director 214-28-1112 MĎ 76 February 22,1931 Usual Residence of Decedent with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Director MD Washington Hancock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be n 21750 **USA** 13922 Orchard Ridge Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 M Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Heavy Equipment Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mina E. Weller James Wesley McCarty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1967 Hykes RD Greencastle, PA 17225 Paul D. McCarty/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/11/07 Orchard Ridge Hancock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or composations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final DISCASK Renal chronic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and s the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 dinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

ARIO 31. Date filed (Month, Day, Year) AUG 1 6 2007 29c. License number

706034

0

and manner stated.

1 5

32. Registrar's Signature

(HE O)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Year Moane y JR.

4b. City, Town, or Location of Death **Physician** 07 2007 11:30 AM ee Edward /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** EASTON
If Under 1 Year I If Under 24 Hrs. Apt. 91 7. Age (In yrs. last birthday) TA/bot Villag 8. Date of Birth (Month, Day, Year)
02-17-1942 5. Social Security Number C Birthplace (State or Foreign Country) **Funeral** Days Hours Min Months 1 M 2 F 65 216-38-8157 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ? Is marked other than "natural, or Items 23a or 28a-f shot traumatic event, Ite Medical Evolutions for notified at 1 Yes 2 □ No Director TAIDOT md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21601 death Was Decedent E/ Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. om 27 is marked othar than Elementary/Secondary (0-12) College (1-4or 5+) Farming HAND Farm 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Moaney Pauline 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/ elationship (Type, Print) Lyes 1 and 2
Lyepartment of Health an Important: If item 27 is r. any injury or other any or other any or other any or other any or other any or other any or other an Apt.91 20b. Place of Disposition (Name of cemetery, crematory or other place) wife ERSTON Md. 21601 Oc. Location - City or Town, State Mary B. N 20a. Method of Disposition 1 Burial 2 Cremation B. Moaney 3 Removal from State 7-28-07 EASton, md. 1 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cem. 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature of Funeral Service Licensee Pint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrivations characteristics. List only one cause on each line.

Approx. Approximate Interval Between Onset and Death ~ 2 4 Caro Immediate Cause (Final disease or condition resulting in death) stage IIIB non-small cell Concer una **Physician** /Medical Due to (or as a nsequence of): Examiner 40 years top deco abuse S uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introdering cause) Examiner attending physician and for use as the burial-transit ardiovascular dusease O years that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ certificate has been signe rector, page 2 should be niatal 1 1 Yes 2 No 3 Probably 4 Unknown anemia verni2 Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 2 No tor: After this certific the funeral director, 25. Was case referred to medical 26. Place of Death Check on one examiner Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

P.O. Box 68760, Division of Vital Records, Hospital or Attending Physician: 24 hours after death.

Funeral Director: A

Baltimore, Maryland 21215-0036

IS PER IME

Medical (Check only one) within 24 29b. Signature and title of certifier

and manner stated.

29d. Date signed (Month, Day, Year) 29c. License number D0059939 2007

2/601

OM, NOE63

Elliott 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Idlewild

508 9851110H 31. Date filed (Month, Day, Year)

State JUL 3 0 2007 Registrar



(

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Marie August 6:15P M Smith Moxley 11 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glade Valley Nursing & Rehab. Ctr. Frederick Walkersville der 1 Year | If Under 24 Hr 8. Date of Birth (Month, Day, Year)
Mar. 25, 1 5. Social Security Number If Under 1 Year Days 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**X**F Months Hours 218-40-1299 95 Director 1912 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once, 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 56 W. Frederick St. U.S.A. 21798 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Charles William Smith Jenny Elizabeth Waltz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol L. Moxley/ daug.-in-law 8502 Mapleville Rd. Mt. Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chapel Cemetery 8/15/2007 nr. Libertytown 22. Name and Address of Facility Hartzler Funeral Home 21. Sign tue of Funeral Service Lic atharine ( 11802 Liberty Rd. Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Grdi · VORCHE therosclerot years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Year 5 ☐ Other (specify) 9☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 2 No 3 Probably 4 ☐ Unknown 1 Tes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 100 မ 1 ☐ Yes 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? After 1 Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 3 Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1058 8-13-07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gene Ashe 10200 Coppermine Rd. Woodsboro, MD 21798 31. Date filed (Month, Day, Year) 6 32. Registrar's Signature State 2007

Registrar

|  | -  | For<br>State<br>Registrar   | S   | tate of Ma   | ırylan                    | -  | artmen<br><i>rtificat</i>             |                          |                                      |                            |                                      | jiene<br>leg. Nó.          | 07   | 2540   |
|--|--|---|---|--|---------------------------|--|---------------------------------------|--------------------------|--------------------------------------|----------------------------|--------------------------------------|----------------------------|--|--|
| Physicia   |  | Decedent's Name (First, Michael HARRIETT)   | dle, Last)  | MASSE  | v                         |  |                                       |                          |                                      |                            | 2. Date of Dea<br>Month<br>AUG.      | Day                        | 007<br>007   | 3. Time of Death                                       |
| /Medica<br>Examine   |  | 4a. Facility Name (If not institut  | ion, give stree   |  | 11                        |  |                                       | Town, or                 | Location o                           |                            | AUG.                                 | 4c. Count                  | y of Death   | 07:22A   |
| Funeral<br>Director  |  | 5. Social Security Number 222-05-3324   | 6. Sex<br>1 ☐ M   |  | (In yrs. I<br><b>84</b>   | ast birthday)<br>Yrs.  | If Under<br>Months                    |                          | If Under<br>Hours                    |                            | 8. Date of Birth<br>Month Day        | 1923                       |  | place (State or Forei                                  |
| or 28e-f show  |  | Usual Residence of Decedent  10a. State 10b. Cour  MD WICC  | )MICO   |  | 10c. City                 | SALIS  |                                       |                          |                                      |                            |                                      |                            |  | 10d. Inside City Limi<br>1 ☐ Yes 2 1                   |
| 23a or 28a   | Funeral Director                                       | 10e. Street and Number<br>6807 HAVASSY  | DRIVE   |  |                           |  | 10f. Zip                              | Code 218                 | 304                                  |                            |                                      | 10g. Citizen of<br>U       | What Cou   | ntry?  |
| at of Heelth and Mental Hyglene. If Item 27 is marked other than "natural", or iteme 23a or 28e-1 show or other treumatic event, the Medical Examinar must be rutilised at   | d by Funer   | 11. Marital Status  1 ☐ Never Married 2 ☐ M 3 🛣 Widowed 4 ☐ Divorc  | arried  | Was Decedent B<br>Armed Forces?<br>1 ☐ Yes 2 ♠ N<br>If Yes, Give<br>Year or Dates: |                           |  | Was Deced<br>If Yes, spe<br>1 Yes     |                          | spanic Ori<br>n, Mexicar<br>Specify: |                            | city Yes or No-<br>Rican, etc.)      | 14. Ra<br>Bla<br>Speci     | ick, White,  |  |
| then "natural",  | Completed by   | 15. Deced<br>(Specify only high<br>Elementary/Secondary (0-12   |   |  | +)                        | (Give<br>life.   | dent's Usua<br>kind of wo<br>DO NOT u | rk done d<br>se retired  | luring mos                           | t of workin                | ng .                                 | 16b. Kind of E             | Business/Ir<br>LOTHI                                       | ·  |
| and mental hygiene.  s marked other than "  sumatic event, the Max   | o Be Co  | 17. Father's Name (First, Middle  |   |  |                           |  |                                       |                          |                                      |                            | (First, Middle,<br>EN WILS           | Maiden Suma                |  |  |
| 27 is mar<br>treumat   |  | 19a. Informant's Name/Relatio   | nship (Type,  |  |                           |  | -                                     |                          |                                      |                            | Route Numbe                          | -                          | , State, Zij<br><b>1804</b>                                | Code)  |
| nent of Heelth<br>int: If Item 27<br>iry or other tr   |  | 20a. Method of Disposition  1 Burial 2 Crematio  4 Donation 5 Other   |   | oval from State  | C                         | lace of Dispendence o | matory or c                           | ther plac                | .                                    | 8/10                       | ate //07                             | 20c. Location  GEORGE      |  |  |
| Department of the formal of the forethe of the formal of the formal of the formal of the formal of t |  | 21. Signature of Funeral Service  Levral  |   | hort   | 101                       | 2  | 2. Name ar                            | nd Addres                | s of Facilit                         | ty SHO                     | ORT FUN<br>GEORGE                    | ERAL SI                    | ERVIC  | ES   |
| /sician<br>ledical<br>aminer   | in in  | 23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate. | or complication of confidence | Due to (or as a  | e.<br>P<br>a consequ      | uence of):   | ter the mod                           | se or ayını              | g, such as                           | cardiac or                 | respiratory ari                      | rest,                      |  | Approximate<br>Interval Between<br>Onset and Death     |
| physicien and the burial-transit   | Physician/Medical Examiner                             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of high that initiated events resulting in death) Last                              | c   | Due to (or as  |                           |  |                                       |                          |                                      |                            |                                      |                            |  |  |
| detached for use as the  | nysician/Med   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   |   | If yes, outcome<br>1 □Live birth<br>4 □ Pregnant at<br>9 □ Unknown                 | 2 🗌 Fetal                 | death 3(   | ∃Ectopic p                            |                          |                                      |                            |                                      |                            | ate of deliv   | ery<br>Day Year  |
| e e e  | ۵  | Part II. Other significant cond   | itions contrib  | uting to death bu  | ıt not resi               | ulting in the u  | inderlying o                          | ause give                | en in Part I                         |                            | 23e. Did to                          | M                          | tribute to t   | he cause of death?<br>bably 4 □Unknow                  |
| 2 2  | Completed  |   |   |  |                           |  |                                       |                          |                                      |                            | 24a. Was a autop perfor 1 Tes        | sy                         | Were auto<br>prior to co<br>death?<br>1 \( \sum \text{Yes} | opsy findings availat<br>impletion of cause of<br>2 No |
| rector   | Be   | 25. Was case referred to medi examiner?   | cal Hose  | oital:   |                           |  |                                       | Othe                     |                                      |                            | (Check only or                       |                            |  |  |
| After th<br>funeral  | 1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 est |   |   |  |                           |  |                                       |                          |                                      |                            | her (Speci.<br>rred                  | Ty)                        |  |  |
| to the Funeral Director. After the completely filled in by the funeral   | Certification:   | 3 Suicide 6 Coudete   | ld not be<br>rmined   | 28e. Place of Injubul  | iry - At ho<br>. (Specify | me, farm, st   | reet, factor                          | y, office                |                                      | 2                          | 8f. Location (S<br>City or Tow       | treet and Num<br>n, State) | ber or Rur   | al Route Number,                                       |
| within 24 hours efter death To the Funerel Director: completely filled in by the   | Medical  | 29a. Certifier 1 Certif<br>(Check only one) 2 Medic   | ying Physicia<br>a Examiner   | on: To the best of<br>On the basic of<br>and manner sta                            | examinat                  | wledge, deal<br>tion and/or in   | h occurred<br>vestigation             | at the tim<br>, in my op | ne, date an<br>pinion, dea           | nd place, a<br>ath occurre | nd due to the d<br>ad at the time, d | ause(s) and materials      | anner as s<br>, and due t                                  | stated.<br>o the cause(s)                              |
| To 1   | Σ/   | 26b. Signature and title of cep   | fier  |  | ) ]                       | 00   | 29                                    | c. License               | number                               | 27                         | - 2                                  | 29d. Date sign             | ed (Month,   | Day, Year)   |
|  |  | 30. Name and address of personal Company Yes  | who comp  | leted cause of de  | ath (Item                 | 13 6   | Print)                                | inple                    | ich i                                | Par                        | ivay                                 | Salu                       | obu  | SIS a MUR  |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** PATRICIA METCALF 08 2007 01 2021 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth Jun 12, 1929 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M Director 218-24-8586 78 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at anne. 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits WV Mineral Keyser 1 ☐ Yes x2 ☐ No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1555 Terri Street 26726 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white **४** ☐ Widowed 4 ☐ Divorced ear or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jessica M. Shillingburg Frederick Byer ၉ 19a. Informant's Name/Relationship (Type. Print) Kim Metcalf 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 1310 Lymar St. Keyser WV 26726 daughter 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Scarpelli Funeral Home, P.A. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/2/2007 Cresaptown MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Nam**Scarbellis Funeral** Home, PA for Fredlock Funeral Home 108 Virginia Avenue: Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) signed by the attending physician be detached for use as the burie Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2<sup>™</sup>No 1 Tyes 3 Probably 4 ☐Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No has autopsy 1□ Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2**X**(No 1 Minpatient 2 ER/Outpatient Certification: To 3□ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1XNatural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical

Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: Hospital

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Drive, Cumberland, MD.

29b. Signature and title of certifier

31. Date filed (Month, Day,

29c. License number

29d. Date signed (Month, Day, Year)

M.D

01

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m. 900 Seton 0

32. Registrar's Signature

2007

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month July **Physician** 25<sup>Day</sup>2007 Year Mary Miller 11:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
Nov. 23 1957 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 🗗 F 49 Director 578-88-0448 Mississippi Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Md Prince George's 1 XYes 2 No Director Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 7410 Parkwood Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify: Black 1 ☐ Yes 2X No Specify \$ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Mail Processor Private permit. Pages 1 and 2 should be filed Department of Health and Mental Hygir Important: If Item 27 is marked other any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack Miller Rosa Lee Ledbetter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7410 Parkwood Street Hyattsville, Maryland 20784 Shaun Miller/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 8/10/2007 Washington, DC 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a Part1. Enter the disc shock, or heart faily se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, b. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Fin **Physician** Sep tramia disease or condition resulting in death) /Medical as a consequence of): Due to (o **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or liquity that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ from mobile televia dysilve, my 2 No 3 Probably 4 Unknown 1 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No autopsy perform 1□ Yes 2₽No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 ☐ Yes ဥ 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manual of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 3 ☐ Suicide

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician the as for use cate has been signed by the page 2 should be detached

certificate

After this

filled in by

Medical

the Hospital or Attending Physician:

death.

hours after within 24 hours aft

To the Funeral D

completely filled in

within 72 hours after death with

than,

Baltimore, Maryland 21215-0036

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

20055120

6 Could not be determined 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and fittle of certifier 29c. License number

. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cimi

Such 310 Washington DC 20032 15

29d. Date signed (Month, Day, Year)

State Registrar

1328 Southern avenue 32. Registrar's Signature

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** -1. 15 P.M JULY 2007 Shirley Ann Mayne /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Western Maryland Hospital Center Hagerstown
If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year)

Hours Min. (Month, Day, Year) Washington Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF Yrs. Director 218-64-2919 69 11/16/1937 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "natural", or items 23a or 28a-f show other treumatic event, it a Mudical Exeminar rotat be notified at 1 X Yes 2 □ No Director Carro11 Maryland | Union Bridge 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 511 Shriner Court 21791 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify. þ 3 ☐ Widowed 4 📉 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other then Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 9 Dietary Supervisor MD State Hosptial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) pe item 27 is marked o David Edward Neff Mary Geneva Cooley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Harrison, daughter 1033 St. Michaels Road, Mt. Airy, Maryland 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olivet Cemetery 8/4/2007 Frederick, Maryland 21. Signature of Funeral Service License 22. Name and Address of FacilityMolesworth-Williams Funeral Home 1 erger 26401 Ridge Road, Damascus, Maryland 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DISTRESS SUNDROME RESPIRATORY **Physician** WEEKS a ADULT disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-trans and Due to (or as a consequence of) Box 68760, ettending physicien Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the e P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown ASTHMA Completed CHRONIC OBSTRUCTIVE PULMONARY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has page 2 autopsy performed 1 Yes 2 No 1 🗌 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 [
28a. Date of Injury
(Month, Day Year) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 9 No ဂ္ 1 🗌 Yes 2 ER/Outpatient 3 DOA this After this funeral of 27. Mannes of Death 28b. Time of 28c. Injury at Work? Certification; 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending death. 1 ☐ Yes 2 ☐ No investigation Director: / 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by hours after 4 | Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medica completely 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number DOOG 2 895 2007 JULY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue Pauline Daley, MD Hagerstown, MD 21742 31. Date filed (Month, Day, Year) State AUG 02 Registrar

DHMH 17 Rev 1/2001

|  | ľ              | 1 - For<br>State<br>Registrar   |  | f Marylan  | d / Dep                        |  | of He                   | ealth a                     | and Me       | ental Hy                                |                          | -                                   | 255                                | . ) )             |
|--|----------------|---|--|--|--------------------------------|--|-------------------------|-----------------------------|--------------|---|--------------------------|-------------------------------------|------------------------------------|-------------------|
| Physicia   | an             | Decedent's Name (First, Middle,   | Last)  |  |                                |  |                         |                             | :            | <ol><li>Date of Dea<br/>Month</li></ol> | ath<br>Day               | Year                                | 3. Time of                         | Death             |
| /Medic   | al             |   | Margare  | et Star  | ling N                         |  |                         |                             |              | August                                  |                          | 2007                                | 7:00                               | РМ                |
| Examin   | er             | 4a. Facility Name (If not institution,  | -  |  |                                |  |                         | Location o                  | of Death     |   |                          | County of Death                     |                                    |                   |
|  |                | College View N  |  |  |                                | -  | deri                    |                             | 24 Uso       |   |                          | rederick                            |                                    |                   |
| Funeral<br>Director  |                | 5. Social Security Number 579-16-6956 Usual Residence of Decedent   | 6. Sex<br>1 □ M 2 🔀 F                                | 7. Age (In yrs. 91                               | Yrs.                           | If Under<br>Months                         | Days                    | If Under :<br>Hours         | Min. A       | B. Date of Birt<br>(Month, Da<br>pril 1 | 7, 1                     | 916 Nort                            | olace (State o<br>ntry)<br>ch Caro | r Foreign<br>lina |
| land   | ı              | 10a. State 10b. County  |  | 10c. Cit   | y, Town or L                   | ocation                                    |                         |                             |              |   |                          |                                     | 10d. Inside Ci                     | ty Limits         |
| Mary   | ģ              | MD Freder   | rick   | Fre  | deric                          | ζ  |                         |                             |              |   |                          |                                     | 1 Yes                              | 2 🗆 No            |
| r 28a  | Director       | 10e. Street and Number  |  |  |                                | 10f. Zip                                   | Code                    |                             |              |   | 10g. Citi                | zen of What Cou                     | ntry?                              |                   |
| h witi   |                | 110 Burgess H   | ill Wav  |  |                                | 21   | 702                     |                             |              |   |                          | USA                                 |                                    |                   |
| deat   | Funeral        | 11. Marital Status  |  | dent Ever in U                                   | .S. 13.                        |  |                         | spanic Orig                 | gin? (Spec   | ify Yes or No-                          |                          | 14. Race - Ameri                    |                                    |                   |
| or ite   | 린              | 1 ☐ Never Married 2 ☐ Marrie  |  |  |                                | 1 Yes 2                                    |                         |                             |              | ilcari, etc.)                           |                          | Black, White,                       | etc.                               |                   |
| ural',   | d by           | 3 Widowed 4 □ Divorced  | Year or Da   | ates:  |                                |  |                         |                             |              |   |                          |                                     | ite                                |                   |
| within 72 hours after death with the Maryland<br>ene.<br>Han "natural", or items 23a or 28a-f show<br>he Madical Examiner must be notified at  | Completed      | 15. Decedent'<br>(Specify only highest  | s Education<br>grade completed)                      |  | 16a. Dece                      | edent's Usua<br>e kind of wor<br>DO NOT us | l Occupa<br>k done di   | tion<br>u <i>ring m</i> ost | t of working | g                                       | 16b. Kii                 | nd of Business/Ir                   | dustry                             |                   |
| withir<br>ene.<br>then   |                | Elementary/Secondary (0-12)   | College (1   | -4or 5+)   |                                | embler                                     | e retired)              |                             |              |   | Dha                      | ne Manuf                            | 00 +1190                           | 24                |
| filed<br>Hygir<br>other<br>ant,  | e C            | 17. Father's Name (First, Middle, L   | ast)   |  | ASSE                           | SIIIDTEL                                   |                         | 18. Mothe                   | er's Name    | (First, Middle,                         |                          |                                     | acture                             | Γ                 |
| d be<br>entai<br>ked o   | To B           | Unkn  |  |  |                                |  |                         |                             |              | ncent                                   |                          | ,                                   |                                    |                   |
| Shou<br>nd M<br>mar  | ۲              | 19a. Informant's Name/Relationsh  |  |  | 19b. Mai                       | ing Address                                | (Street a               |                             |              |   | r, City o                | r Town, State, Zij                  | Code)                              |                   |
| elth a   |                | James Mattia -  | Son  |  | 68 I                           | Potoma                                     | c Me                    | adow                        | Lane         | - Har                                   | pers                     | Ferry,                              | WV 254                             | 25                |
| of He itam   |                | 20a. Method of Disposition  | - (75  | 20b. P   | Place of Disp<br>cemetery, cre | osition (Name                              | ne of<br>ther place     | ) I                         | Da           | ite                                     | 20c. Lo                  | cation - City or T                  | own, State                         |                   |
| Pege<br>nent of  |                | 1 ☐ Burial 2 🂢 Cremation<br>4 ☐ Donation 5 ☐ Other (Sp  |  |  | gersto                         |  |                         |                             | 8/3/2        | 2007                                    | Hag                      | gerstown                            | , MD                               |                   |
| permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. I show the contractural if them 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic avant, the Madical Examinar must be notified at once. |                | 21. Signature of Funeral Service L  | icensee  |  | 2                              | 2. Name and                                | d Address               | s of Facilit                | ty Eac       | kles-S                                  | ence                     | er & Nor                            | ton Fu                             | neral             |
| 807 2 9  | _              | Robert L.   | Spenn  | M9   | 70 I                           | Home -                                     | Har                     | pers                        | Ferr         | y, WV 2                                 | 2542!                    | 5                                   |                                    |                   |
|  |                | 23a. Part1. Enter the disease, or o shock, or heart failure. List of  | complications that cannot one cause on e             | aused the deat<br>ach line.                      | h. Do not er                   | nter the mode                              | of dying                | , such as                   | cardiac or   | respiratory ar                          | rest,                    |                                     | Approximate<br>Interval Bety       | ween              |
| Physician  |                | Immediate Cause (Final disease or condition   | Dev  | nont   | 19                             |  |                         |                             |              |   |                          |                                     | Onset and [                        | Jeath             |
| /Medical<br>Examiner   |                | resulting in death)   | Due to (   | or as a conseq                                   | uence of):                     |  |                         |                             |              |   |                          |                                     |                                    |                   |
|  | _              | Sequentially list conditions,   | b. — Dup to /  | or as a conseq                                   | uonan of).                     |  |                         |                             |              |   |                          |                                     |                                    |                   |
| led<br>sit   | ulue           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (   | oi as a conseq                                   | derice or).                    |  |                         |                             |              |   |                          |                                     |                                    |                   |
| sicien and<br>burial-transit   | Examiner       | that initiated events resulting in death) Last  | c  | or as a conseq                                   | uence of):                     |  | -                       |                             |              |   |                          |                                     |                                    |                   |
| on cie   | calE           |   | d.   |  |                                |  |                         |                             |              |   |                          |                                     |                                    |                   |
| ifficat<br>g phy<br>as th  |                |   | J  |  |                                |  |                         |                             |              |   |                          |                                     |                                    |                   |
| th cer<br>endin  | N/UE           | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, out                                     | come of pregna                                   |                                | □Ectopic pre                               | 2002004                 |                             |              |   | 2                        | 23d. Date of deliv                  | өгу                                |                   |
| sicien: The law requires thet the death certificate certificate best been signed by the attending physirector, page 2 should be detached for use as the i  | Physician/Med  | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   |  | ant at time of d                                 |                                | Other (spe                                 |                         |                             |              |   |                          | Month                               | Day 1                              | rear              |
| thet t   |                | Part II. Other significant condition  | ns contributing to de                                | eath but not res                                 | ulting in the                  | underlying ca                              | ause give               | n in Part I.                |              | 23e. Did to                             | obacco u                 | se contribute to t                  | he cause of d                      | eath?             |
| quires<br>n sign   | d by           | History o-  | - ovar   | ian  | Car                            | CPV  |                         |                             |              | 101                                     | 'es 2[                   | □No 3□Pro                           | oably 4 □L                         | Jnknown           |
| s bee  | lete           | Probable  | Gaster   |  |                                | •  |                         | lien                        | an li        | 24a. Was                                | an                       | 24b. Were auto                      | opsy findings                      | available         |
| The ia   | Completed      | 1 10 150 15 18  | Masici   |  |                                | 1071                                       | 101 /                   | 1 / 1 /6                    |              |   | rmed?                    | prior to co                         | impletion of ca                    | ause of           |
| rtifice  | 0              | 25. Was case referred to medical  |  |  |                                |  |                         | 26. Place                   | of Death     | 1 ☐ Yes<br>(Check only o                | 2∭ No<br>ne)             | 1 🗆 Yes                             | 2 NO                               |                   |
| Physician:<br>r this certifice<br>ral director, I  | To B           | examiner?<br>1 ☐ Yes 2 ※ No   | Hospital: † 🗆 I                                      | npatient 2                                       | ER/Outpatie                    | ent 3 DO                                   | A Othe                  | r: 4∭ Nu                    | ırsing Hom   | e 5 Resid                               | lence (                  | 6 ☐Other (Speci                     | fy)                                |                   |
| og Pl  |                | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of (Mont                                   | of Injury<br>h, Day Year)                        | 28b. Time<br>Injury            | of 2                                       | Bc. Injury<br>Work      | at<br>?                     | 21           | 8d. Describe h                          | ow injur                 | y occurred                          |                                    |                   |
| Attanding<br>ir death.<br>actor: After<br>by the fune  | catl           | 2 Accident investig   | ation  |  |                                | М  |                         | 'es 2 □ I                   | No           |   |                          |                                     |                                    |                   |
| of or At<br>effer<br>Dirac<br>d in by  | Certification: | 4 Homicide determine  | ned 286. Place                                       | of Injury - At he<br>ng, etc. (Specif            | ome, farm, s                   | treet, factory                             | , office                |                             | 28           | 8f. Location (S<br>City or Tov          | Street and<br>vn, State, | d Number or Run<br>}                | al Route Num                       | ber,              |
| To the Hospitel or Attending Physicien: The is within 24 hours effer death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page  | Medical C      | 29a. Certifier 1 Certifying (Check only one)  | Physician: To the<br>examiner: On the ba<br>and mann | best of my kno<br>asis of examina<br>ner stated. | wledge, dea<br>ition and/or i  | th occurred anvestigation,                 | at the time<br>in my op | e, date an<br>inion, dea    | nd place, ar | nd due to the                           | cause(s)<br>date and     | and manner as s<br>place, and due t | stated.<br>o the cause(s           | )                 |
| To t<br>To t   | Σ              | 29b. Signature and title of certifier   | -11  |  |                                |  | License                 |                             |              |   | 29d. Dat                 | e signed (Month,                    | Day, Year)                         |                   |
|  |                |   | 5  | Mb   |                                | 0  | 00                      | 604                         | 117          |   | 8/2/                     | /2007                               |                                    |                   |
| 4  |                | 30. Name and address of person w<br>Hemen Shah, MD  |  |  |                                |  | - F:                    | reder                       | cick,        | MD 217                                  | 702                      |                                     |                                    |                   |
| Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)   | 20.0   | gistrar's Signa                                  |                                |  |                         |                             |              |   |                          |                                     |                                    |                   |
|  |                |   |  |  |                                |  | -                       |                             |              |   |                          |                                     |                                    |                   |

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Marie Theresa Melton 28 2007 3:00P 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Caroline Nursing Home
5. Social Security Number 6. Sex 7. A Caroline Denton If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 XF Months Hours 089-20-4859 80 Jan\_11 1927 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 315 Sunset Ave. 21639 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Donat Willett Edna Arbour Willett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Wilczenski / daughter
20a. Method of Disposition 20b. Plac 104 Maple Ave; Greensboro, MD 21639 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 1 St Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Greensboro Cemetery 8/2/07 Greensboro, MD 21. Signature of Foneral Service Licensee 22 Name and Address of Eachily Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Box 160 Greensboro, MD 21639 he mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Do not enter shock, or heart failure. List only one cause o Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

Нета 23а

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if Health and Mental Hygiene. Item 27 is marked other then

permil. Pages Department of Important: If it any injury or o

**Physician** 

Examiner

/Medical

attending physician and for use as the burial-transit

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To the Funeral Director:

page 2 should

The law requires that the death certificate be executed

To the Hospitel or Attanding Physician:

Division of Vital Records, P.O. Box 68760

Directo

Funeral

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Completed

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Examine

Physician/Medical

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Completed

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Certification:

Medical

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be notified as

DHMH 17 Rev 1/2001

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, hours after death.

uneral Director: A within 24 hours af

To the Funeral D

completely filled in

25365 Point Lookout Road, Leonardtown, Maryland 20650 32 Registrar's Signature

ed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier,

William D. Boyd, II,

30. Name and address of person who comple

AUG 07

M.D.

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene.

|                            |   |                  | 1-        | For<br>Stata<br>Registrar  | 0.0.0                                | , <b>,</b>                        | Cer                    | tificate of                           |   | noma, m                                       | Reg. No.                               |                               |   |
|----------------------------|---|------------------|-----------|--|--------------------------------------|-----------------------------------|------------------------|---------------------------------------|---|---|--|-------------------------------|---|
|                            | <b>.</b>  |                  | 1. E      | Decedent's Name (First, Middle, Las  | t)                                   |                                   |                        |                                       |   | 2. Date of De                                 |  | V                             | 3. Time of Death                                      |
|                            | Physici<br>/Medio   |                  | F         | rederick William   | n Nagle                              | rIII                              |                        |                                       |   | July  | 24 2007                                | Year<br>7                     | 12:30P M  |
|                            | Examir  |                  |           | Facility Name (If not institution, give  |                                      |                                   |                        | 4b. City, Town, o                     | or Location of Death                        |   | 4c. County of                          | f Death                       |   |
|                            |   |                  | F         | Peninsula Regiona  | al Medio                             | cal Cen                           | ter                    | Salisb                                | ıry   |   | Wicomi                                 | ico                           |   |
|                            | Funeral<br>Director   |                  | 21        | .0-20-0304   | ox<br>□M 2□F                         | 7. Age (In yrs.<br>80             | last birthday)<br>Yrs. | If Under 1 Year<br>Months Days        |   | 8. Date of Bi<br>(Month, Date of Bi<br>Dec. 2 | ay, Year)                              | 9. Birthpl<br>Count<br>(1ary) |   |
|                            | and *   |                  |           | ual Residence of Decedent  1. State 10b. County  | -                                    | 10c. Cit                          | ty, Town or Loc        | ration                                |   |   |  | 10                            | Od. Inside City Limits                                |
|                            | ehow  | 5                |           |  |                                      |                                   |                        |                                       |   |   |  | ,                             | 1 Yes 2 No  |
| 5                          | the M   | ect              | —         | ryland Wicomico  |                                      | Sa                                | lisbury                | 10f. Zip Code                         |   |   | 10- 04                                 |                               |   |
| 3                          | ath with the Maryla<br>23a or 28e-f ehor  | Funeral Director |           | 6445 Centennial I  | rive                                 |                                   |                        | 2180                                  | 1   |   | 10g. Citizen of W                      | nat Coun                      | iry?  |
| 2                          | er death w<br>iteme 23a   | ner              | 11.       | Marital Status   | 12. Was Dece                         | edent Ever in U                   | S. 13. V               |                                       | Hispanic Origin? (Sp<br>an, Mexican, Puerto | pecify Yes or N                               | o- 14. Race                            | - America                     | an Indian,  |
| Maryland 21215-0036        | ours aff  | b                |           | 1 ☐ Never Married 2 🛣 Married<br>3 ☐ Widowed 4 ☐ Divorced  | 1 X Yes<br>If Yes, Giv<br>Year or Di | <sup>2</sup> No 194               |                        | Yes 2∑ No                             |   | Hican, etc.)                                  |  | White, e                      |   |
| 5-0                        | 72 h  | etec             |           | 15. Decedent's Ed<br>(Specify only highest gra   |                                      |                                   | 16a. Deced             | ent's Usual Occup                     | pation<br>during most of work               | kina  | 16b. Kind of Bus                       | siness/Ind                    | ustry   |
| 121                        | d within 72 ho<br>piene.<br>r then "natur<br>r he wad cal   | Completed        | E         | Elementary/Secondary (0-12)  | College (1                           | -4or 5+)                          | life. C                | o NOT use retire                      | rd)   | ung   | Applian                                |                               |   |
| 2                          | 71  |                  | 17.       | Father's Name (First, Middle, Last)  |                                      |                                   | bare                   | S reison                              |   | e (First, Middle                              | Appliar  , Maiden Sumame               |                               |   |
| an                         | s 1 and 2 should be filed<br>if Heelth and Mental Hygi<br>Item 27 is marked other<br>other traumatic event, I   | o Be             |           | rederick William   | Naolei                               | r. Ir                             |                        |                                       |   |   | y Marklar                              | -                             |   |
| 2                          | should Ind Men  | 스                | -         | a. Informant's Name/Relationship (7  |                                      | . 9 01.                           | 19h Mailin             | a Address /Street                     | and Number or Ru                            |   |  |                               | Codel   |
| Sa                         | d 2 s<br>th an<br>t7 is<br>trau   |                  |           | Marie Nagler/Wife  |                                      |                                   |                        |                                       |   |   |  |                               | ,   |
| တ်                         | item 27 i   |                  | _         | . Method of Disposition  |                                      | 20b. F                            |                        | sition (Name of latory or other pla   | ial Drive                                   | Date  | 20c. Location - C                      |                               |   |
| Baltimore,                 | permit. Pages<br>Department of t<br>importent: If its<br>eny injury or of<br>once.  |                  | 0.1       | 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify   | Entomb                               |                                   | comico                 | Mem. Par                              | ck 7/30,                                    |   | Salisbur                               | у, М                          |   |
| Bal                        | Depa<br>impo<br>eny ii  |                  |           | Signature of Funeral Service Licely  | gell                                 | ec                                | Ze<br>12               | ller Fur<br>12 Old (                  | ess of Facility<br>neral Home<br>Ocean City | P. O<br>Road,                                 | Box 317<br>Salisbur                    | 71<br>y, M                    | D 21802   |
|                            |   | Ų                | 22        | a. Part . Enter the disease, or comp<br>shock, or heart failure. List only                                 | olications that copie cause on e     | aused the deat<br>ach line.       | h. Do not ente         | or the mode of dy                     | ng such as cardiac                          | or respiratory a                              | arrest,                                |                               | Approximate<br>Interval Between                       |
|                            | Physician   |                  | lm<br>dis | mediate Cause (Final ease or condition   |                                      | Sef                               | itor                   | ) Yes                                 | ntricat                                     | w X   | 57h 11                                 | -                             | Onset and Death                                       |
| 7                          | /Medical  |                  | res       | sulting in death)  | Dyete                                | or as a conseq                    | juence of):            | 6                                     | 0   |   | 1/2                                    | 77                            | 01100   |
|                            | Examiner  |                  | Se        | quentially list conditions   | b                                    | cher                              | nec                    | Conre                                 | ifin !                                      | on di   | 12 dom                                 |                               | T   |
|                            | ם ב   | Examiner         | if a      | quentially list conditions,<br>ny, leading to immediate<br>use. Enter Underlying<br>use (Disease or injury | Due to                               | or as a conseq                    | juence of):            | 1                                     |   | _   |  | 1                             |   |
|                            | icate be executed<br>physicien and<br>s the burial-transit  | am               | เกล       | use (Disease or injury<br>t initiated events<br>sulting in death) Last                                     | c                                    | nor                               | en /                   | X                                     | 7 ()  | zec.  | ` ــــــــــــــــــــــــــــــــــــ |                               | 37  |
| 90,                        | sien s  |                  | 103       | uning in death, cast   | Due to (                             | or as a conseq                    | luence pt):            |                                       |   |   |  |                               | J   |
| 68760,                     | ate b<br>hysic<br>the b   | Medical          |           | •  | d                                    |                                   |                        |                                       |   |   |  | _                             |   |
|                            | ₩ On 60   |                  | 1E        | FEMALE:  |                                      |                                   |                        |                                       |   |   |  |                               |   |
| O. Box                     | ne death<br>the atter<br>hed for u  | by Physician/    |           | b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown                                      |                                      | inth 2 ☐ Feta<br>ant at time of d | Il death 3 🗌           | Ectopic pregnand<br>Other (specify) _ | у   |   | 23d. Date<br>Mon                       |                               | Day Year  |
| , P.O                      | res that the signed by be detaction   | y Ph             | Par       | t II. Other significant conditions co  | ontributing to de                    | eath but not res                  | ulting in the un       | derlying cause gr                     | ven in Part I.                              | 23e. Did                                      | tobacco use contri                     | bute to the                   | e cause of death?                                     |
| Division of Vital Records, | w requires<br>been sign<br>should be  | ed b             | _         |  |                                      |                                   |                        |                                       |   | 10  | Yes 2 □ No                             | 3 ☐ Proba                     | ably 4 Danknown                                       |
| သို                        | e law re<br>hes be<br>je 2 sho  | Completed        |           |  |                                      |                                   |                        |                                       |   | 24a. Was                                      | an 24b. W                              | ere autop                     | sy findings available                                 |
| č                          | The lav   | E                |           |  |                                      |                                   |                        |                                       |   | auto<br>perf                                  | ormed? de                              | eath?                         | sy findings available<br>apletion of cause of<br>2 No |
| ta                         | ician: Th<br>certificate<br>ector, pag  | BeC              | 25.       | Was case referred to medical   |                                      |                                   |                        |                                       | 26. Place of Dea                            | 1   |  |                               |   |
| >                          | ysici<br>is ca<br>direc   | ToE              |           | examiner? 1 Yes 2 No   | Hospital:                            | npatient 2                        | ER/Outpatient          | 3□ DOA Ot                             | 000   |   | idence 6 Othe                          | r (Specify                    | )   |
| 0                          | g Ph<br>ter th<br>heral   |                  |           | Manner of Death  | 28a. Date                            | of Injury<br>h, Day Year)         | 28b. Time of<br>Injury | 28c. Inju<br>Wo                       |   |   | how injury occurre                     |                               | ,   |
| <u>.</u>                   | ath.<br>ath.<br>r: Af   | atio             |           | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation   |                                      | ii, Day 16ai)                     | Hijary                 |                                       | Yes 2 □No                                   |   |  |                               |   |
| ivis                       | To the Hospital or Attending Physician: within 24 hours eller death. To the Funeral Director: After this certific completely filled in by the funeral director, | Certification;   |           | 3 Suicide 6 Could not be determined  | 289. Place                           | of Injury - At h                  | ome, farm, stre        | et, factory, office                   |   | 28f. Location (                               | (Street and Number<br>wn, State)       | r or Rural                    | Route Number,   |
|                            | pital   |                  | 29        | a. Certifier 1 Certifying Ph   | veicien: To the                      | boot of my kar                    | uulodgo dooth          |                                       | me, date and place,                         |   |  |                               |   |
|                            | Hose Hose   | Medicai          |           | (Check only 2 Madical Examone)   | iiner: On the ba                     | asis of examina                   | ation and/or inv       | estigation, in my                     | opinion, death occur                        | red at the time                               | date and place, a                      | nd due to                     | the cause(s)  |
|                            | Withir<br>To th   | M                | 29t       | o. Signature and title of pertifier  | 1-1                                  |                                   |                        | 29c. Licens                           | se number                                   |   | 29d. Date signed                       | (Month, L                     | Day, Year)  |
|                            |   |                  |           | 1 2 /  | 1/                                   | 7                                 |                        |                                       | 2049  | 1/  | 7-2                                    | 4.0                           | 7   |
| <del></del>                |   |                  | 30.       | Name and address of person who   | completed caus                       | e of death (Iter                  | n 23a) (Type, F        |                                       |   | 1   |  | *                             |   |
|                            |   |                  | 1         | OO E. Carroll  | St                                   | Salish                            | our u                  | mD                                    | 21801                                       | JOSE  | ph L. R                                | laffa                         | etto M.D.   |
|                            | Sta   |                  | 31.       | Date filed (Month, Day, Year)  | 007 32                               | egistrar's Signa                  |                        | and le                                |   |   |  |                               |   |
|                            | Registr   | ar               |           | JOE O T S  | 701                                  | Section 1                         | C AND                  |                                       |   |   |  |                               |   |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** harles R. Noren 9:51 PM OUA 7005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center
5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) Baltimore If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. . Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 □ F 521-58-7473 Director February 20, 1945 Illinois Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits show an "natural", or items 23a or 28a-f shov Medical Examiner must be notifled at 1 ☐ Yes 2 ☐ No Director Caroline Maryland Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24652 Long Branch Drive 21629 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1970-Maryland 21215-0036 1 ☐ Yes 2√2 No þ 3 Widowed 4 Divorced 1972 Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) injury or other traumatic event, the Dentistry Pages 1 and 2 should be filed vent of Health and Mental Hygicint; if item 27 is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Helen Virginia Kirkpatrick Charles Harding Noren ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sherry F. Noren Wife PO Box 8, Denton, Maryland 21629 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important; If t Capitol Crematory 8/3/2007 Dover, Delaware 22. Name and Address of Facility
Moore Funeral Home, P.A.
12 South Second Street, Denton, Maryland 21629 21. Signature of Funeral Service License . Yu bone 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underh in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of) attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 2 No 3 Probably 4 Unknown cate has been si 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
Yes 2 No certificate has Division or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2**☑** No 1 Nnpatient r 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending Injury 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

Chenell

31. Date filed (Month

dee HI

225. Greene

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Donadee

MD

16646

Baltimore, MD 21201

2007

|                |   |                   | 1 - For<br>State<br>Registrar  | State of Ma  | -  | •   | ment of I   |   |              | -                                      | giene<br>Reg. No:       |  | 264 (  |
|----------------|---|-------------------|--|--|--|---|---|---|--------------|--|-------------------------|--|--|
|                | Physici<br>/Medic   | _                 | Decedent's Name (First, Middle   | John   | O'Bri                                    |   |   |   |              | 2. Date of De<br>Month<br>08           | ath<br>06               | 2007   | 3. Time of Death 1:15 p <sub>M</sub>         |
|                | Examin  | er                | 4a. Facility Name (If not institution, Future Care of (  | hesapeake  |  | A   | c. City, Town,  |   |              |  | An                      | unty of Death<br>ne Arur                             |  |
|                | Funeral<br>Director   |                   | 5. Social Security Number 204-03-2353 Usual Residence of Decedent  | 6. Sex 7. Age 1  | 85 Y                                     |   | Under 1 Year<br>lonths Days                               |   | Min.         | 8. Date of Bir<br>(Month, Da<br>12-10- | 1921                    | Cour   | lace (State or Foreign<br>htry)<br>Sylvania  |
|                | Maryland<br>a-f show  | ctor              | 10a. State 10b. County  MD Anne Ar   | undle  | 10c. City, Town                          |   |   |   |              |  |                         | 1  | 0d. Inside City Limits 1 X Yes 2 No          |
|                | th with the<br>23s or 28<br>1st be no   | Funeral Director  | 10e. Street and Number 216 McKeon Roa  | ıd   |  | 1   | 10f. Zip Code<br>2:                                       | 1146                                    |              |  | 10g. Citizen            | of What Cour<br>USA                                  | ntry?  |
| 5-0036         | urs after deal  | þ                 | 11. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3☐ Widowed 4 ☐ Divorced  | 12. Was Decedent E Armed Forces?  1 XYes 2 N If Yes, Give Year or Dates: | lo                                       |   | Decedent of es, specify Cub                               |   |              | cify Yes or No<br>Rican, etc.)         | i .                     | Race - Americ<br>Black, White,<br>ec <i>ify:</i> Whi | etc.   |
| 21215-0        | be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23a or 28a-f show other then "natural", or items 23a or 28a-f show event, The Medical Examiner must be notified at | Completed         | 15. Decedent<br>(Specify only highes<br>Elementary/Secondary (0-12)<br>12  |  |  | Decedent'<br>'Give kind<br>life. DO f<br>duca | t's Usual Occu<br>d of work done<br>NOT use retire<br>tor | pation<br>during mo<br>ad)              | st of workii | ng                                     |                         | of Business/Ind<br>ation                             | dustry                                       |
| Maryland 2121  | b d ta  | To Be C           | 17. Father's Name (First, Middle, L<br>Jose  | eph O'Brien  | <u>'</u>                                 |   |   | 18. Moth                                |              | (First, Middle,                        |                         | name)  |  |
|                | and 2 shouealth and N n 27 is mail  |                   | 19a. Informant's Name/Relationsh<br>Molly O'Brien,   |  |  |   |   |   |              | na Park                                |                         |  | Code)  |
| ltimore,       | - I 9 5   |                   | 20a. Method of Disposition  1  Burial 2 XCremation 4  Donation 5 Other (Sp   |  | 20b. Place of C<br>cemetery,<br>Smithsbu | , cremato                                     | ory or other pla  |   | 08-08-       | 2007                                   |                         | on - City or To                                      |  |
| Balt           | permit. Pages Department of Important: If i eny injury or once.   |                   | 21. Signature of Funeral Service L   | Les Daniel   |  |   | ame and Addr  |   | J.           | L. Dav                                 |                         |  | Home<br>nd 21783                             |
| d              | Physician // Medical Examiner   | i Examiner        | 23a. Part Four the disease, a shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, of any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to (or as a b. Due to (or as a c.                                 | the death. Do not e.                     | UCU   | ne mode of dy   | ng, such a                              | s cardiac o  | r respiratory ai                       | rrest,                  |  | Approximate Interval Between Onset and Death |
| P.O. Box 68/60 | I the death certific<br>by the attending p<br>ached for use as  | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  | 23c. If yes, outcome of the birth 4 Pregnant at 9 Unknown                | 2 Fetal death                            |   | topic pregnanc<br>her (specify) _                         | ;y                                      |              |  | 23d.                    | Date of delive<br>Month                              | ory<br>Day Year                              |
| ecords, t      | w requires that<br>been signed t<br>should be det   |                   | Part II. Other significant condition   | s contributing to death bu   | it not resulting in t                    | the under                                     | rlying cause gr   | ven in Part                             | I.           |  | obacco use d<br>Yes 2 N |  | ably 4 Dunknown                              |
| Vital Reco     | The<br>ete h<br>page  | Completed by      |  |  |  |   |   |   |              | 24a. Was<br>autor<br>perfo             |                         | prior to cor<br>death?                               | psy findings available inpletion of cause of |
|                | Physician: Th<br>this certificete<br>ral director, pag  | To Be             | 25. Was case referred to medical examiner?  1 Yes 2 No   | Hospital: 1  Inpatie   |  |   | 3 DOA   | her:                                    |              | Check only one 5 Residence             |                         | Other (Specify                                       | <i>(</i> )                                   |
| Division of    | ding<br>h.<br>After<br>fune   | Certification:    | 27. Manner   Ceath  1    atural  | ation  | y 28b. Tir<br>Year) Inj                  | ury   | 28c, Inju<br>Wo<br>M 1                                    | ry at<br>rk?<br>] Yes 2 [               |              | 8d. Describe                           | how injury od           | curred   |  |
| 2              | Hospitel or Attending Physicien:<br>44 hours alter death:<br>Funeral Director: After this certific<br>tely filled in by the funeral director.   |                   | 4  Homicide determi  | ned 289. Place of Inju-<br>building, etc                                 | . (Specify)                              |   |   |   |              | City or Tov                            | vn, State)              |  | l Route Number,                              |
|                | To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: oumpletely filled in by the  | Medical           | 29a. Certifier (Check only one)  1 Certifying 2 Medical E  | Physician: To the best of<br>xaminer: On the basis of<br>and manner sta  | examination and/                         | death occ                                     | igation, in my  | ime, date a<br>opinion, de<br>se number | ind place, a | ed at the time,                        | date and pla            | I manner as st<br>ce, and due to<br>gned (Month, i   | the cause(s)                                 |
|                | 8 4 5   |                   | 30 Name and a ress of per on v   | M  | seth (ham 2 la) (                        | UL  | >   | D5                                      | 070          | 25 6                                   | 8 -                     | 7-0  | 2007   |
|                | Sta<br>Registr  | te<br>ar          | 31. Date filed (Month, Day, Year)  | 2. Registra  | 01.100                                   | ype, Print                                    | stru  | 46                                      | lille        | 10,10                                  | le,                     | MÒ   | 24108  |

DHMH 17 Rev 1/2001

Amend State of Maryland / Department of Health and Mental Hygiene 1 tem 8, per fh, 2878, 04,0870 Block of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Day Mary Lou 0'De11 , 2007 /Medical August 5:45 p 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 24044 North Patuxent Beach Road California St. Mary's 5. Social Security Number Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) If Unde Hours **Funeral** Months Days 1 □ M 2 X F Min. 10/07/1942 Director 228-60-9855 64 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show miner must be notifled Director 1 ☐ Yes 2X No Maryland | St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Items 23a 24044 North Patuxent Beach Road Funeral 20619 United States 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 🛣 No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White the Medical Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Systems Analyst U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Important: If Item 27 is marked any Injury or other traumatic evonce. ဂ John Hilary Jones Mazie Elizabeth Pilkerton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald L. McGee, Sr./Son 45470 Steer Horn Neck Road, Hollywood, MD ce of Disposition (Name of Date 20c. Location - City or Tow 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Charles Memorial Cem. 08/10/2007 Leonardtown, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** encer obastatic 2-07-06 /Medical Examiner Melas if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine sease sician and burial-trans MOONE Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death Day 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? 1 ☐ Yes 2 ☐ No 1∐ Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 24 hours after deatle Funeral Director; 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) the within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054263 address of death (Item 23a) (Type, Print) ookout Rd Leonardtown, MD 20650 25500 Pt State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 9, Day 2007 Yeer Beulah Viola Phillips 11:52 рм 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Williamsport Retirement Village Williamsport Washin qton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Apr. 15, 1911 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min. 1□ M 2 4 Yrs 96 Maryland 219-56-5306 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll Taneytown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 118 E. Baltimore St. 21787 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2 No 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify. Specify: 3 Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gordon Stonesifer Mary Grim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16802 Sterling Rd., Williamsport, MD Fred E. Phillips, Sr./son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/14/2007 Keysville, MD Keysville Union Cem. 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Funeral Service License John M. Skiles M00534 136 E. Baltimore St., Taneytown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) my ocardial infarction 2 hours Due to (ocas a consequence of): atheroscierotic heart disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown dementia 24b. Were autopsy findings available prior to completion of cause of death? blindness 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 1 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number. City or Town, State) determined 4 Thomicide 29a. Certifier

Physician /Medical Examiner The law requires that the death certificate be executed the burial-transit P.O. Box 68760, esu. of Vital Records, page 2 should be or Attending Physician: ours after death.

•rai Director: After this certific filled in by the funeral director. Division Hospitai

within 24 hours a
To the Funeral C

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ehow.

or 28a-

238

deeth or iteme

filed within 72 hours after

Il Hygiene.

Pages 1 and 2 should be filed w then of Health and Mental Hygien tant: If Item 27 is marked other ti jury or other traumatic event, in

permit. Page Depertment ( Important: If any injury or

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Director

Funeral

Be Completed by

2

Examiner

Physician/Medicai

Completed by

Certification: To Be

Medicai

State Registrar

29b. Signature and title of certifier

Cynthia Kuttner Sands no

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D47451

29d. Date signed (Month, Day, Year) August 10, 2007

Cynthia Kuther Sands MD. 154 North Artizan Street Williamsport, Mary land 31. Date filed (Month, Day, Year)

AUG 1 6 2007

2. Registrar's Signature

To the h

|                     |  |                 | 1 - For Amend<br>StatAmend<br>Registrar   | l #31,   | 8-3-07, p                             | of Mar<br>er H                        | yland / De<br>CHD, al        | partment of I<br>ertificate of                           | lealth an<br>Death                | d Mental Hy   | /giene<br>Reg. No.        | 2007                                  | 26417   |  |
|---------------------|--|-----------------|---|--|---------------------------------------|---------------------------------------|------------------------------|--|-----------------------------------|---|---------------------------|---------------------------------------|---|--|
| F                   | Physicia   | an              | Decedent's Name   | e (First, Midd   | le, Last)                             |                                       |                              |  |                                   | 2. Date of D<br>Month                                 | eath<br>Day               | / Year                                | 3. Time of Death                              |  |
| 10                  | /Medic   |                 |   |  | RINTZ                                 |                                       |                              |  |                                   | JULY  | 30                        |                                       | 10:12 P <sup>M</sup>                          |  |
|                     | Examin   | er              | 4a. Facility Name (I  |  | n, give street and n<br>MORIAL HO     |                                       | \ T                          | 4b. City, Town, o  |                                   | eath  | 4c.                       | County of Death FREDERIC              | מזכ   |  |
|                     | Funeral  |                 | 5. Social Security N  |  | 6. Sex                                |                                       | וויג<br>In yrs. last birthda |  |                                   | Hrs. 8. Date of Bi                                    | rth                       | 9. Birthi                             | place (State or Foreign                       |  |
| L                   | Director   |                 | 262-31-3<br>Usual Residence of  |  | 1 ☐ M 2 ☐ XF                          |                                       | 53 Yrs.                      | Months Days  | Hours N                           | Jan 27  | , 195                     | Cou                                   | ana   |  |
|                     | laryland<br>show   | J.              | 10a. State  | 10b. County  |                                       |                                       | 0c. City, Town or            |  |                                   |   |                           |                                       | 10d. Inside City Limits                       |  |
|                     | the M<br>28a-f<br>lotific  | Director        | MD<br>10e, Street and Nur   | Frede  | rick                                  | V                                     | Valkersv:                    | 10f. Zip Code  |                                   |   | 10- 04                    | of 14/h =4 C                          |   |  |
|                     | with a or  |                 | 100 Sava  |  | ourt                                  |                                       |                              | 21793  |                                   |   | USA                       | izen of What Cou                      | ntry ?  |  |
|                     | ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other them "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at  | Funeral         | 11. Marital Status 1 □ Never Marri  |  | 12 Was Do                             | cedent Eve<br>orces?<br>2 X No<br>ive | er in U.S. 1                 | 3. Was Decedent of I<br>If Yes, specify Cub              |                                   | ? (Specify Yes or Nuerto Rican, etc.)                 |                           | 14. Race - Ameri<br>Black, White,     |   |  |
| 036                 | ours a<br>al'', o<br>Exam  | by              | 3 Widowed   | 4 ☐ Divorced   | If Yes, G<br>Year or                  | live<br>Dates:                        |                              | 1 ☐ Yes 2 🛣 No   | Specify:                          |   |                           | Specify: Whi                          | te  |  |
| 2-0                 | 72 hc<br>natur<br>dical  | eted            | (Spec   | 15. Deceder  | nt's Education<br>est grade completed | ")                                    | / (G                         | cedent's Usual Occu<br>ve kind of work done              | during most of                    | working   | 16b. Ki                   | ind of Business/Ir                    | dustry  |  |
| Maryland 21215-0036 | within iene.   | Completed       | Elementary/Seco   |  |                                       | /<br>(1-4or 5+)                       | life                         | . DO NOT use retire                                      | d)                                | Working   |                           | <b>n</b> .                            |   |  |
| 2                   | filed w<br>Hygie<br>nther ti   |                 | 17. Father's Name   | (Eirot Middle  | Lost                                  |                                       | Driv                         | er   | 10 Matharia                       | Name (First, Middle                                   | 1                         | Parts                                 |   |  |
| anc                 | ld be fental F<br>ked of<br>ic ever  | o Be            | Tulis Be  | ,  | , Last)                               |                                       |                              |  |                                   | Irene Fre   |                           | •                                     |   |  |
| Ž                   | sho Id   | ř               | 19a. Informant's Na   |  | ship (Type, Print)                    |                                       | 19b. Ma                      | iling Address (Stree                                     |                                   | or Rural Route Number, City or Town, State, Zip Code) |                           |                                       |   |  |
|                     | 1 and 2 sho<br>Health and<br>em 27 is m  |                 | Rhonda H  | ernand   | ez/daught                             | er                                    | 100                          | Savannah   | Ct. Wal                           | lkersvill<br>   | e, MI                     | 21793                                 |   |  |
| Baltimore,          | permit. Pages 1 Department of H Important: If Itel any Injury or oth   |                 | 20a. Method of Disp<br>1 ☐ Burial 2<br>4 ☐ Donation   | X Cremation  | 3 □Removal fror<br>Specify)           | n State                               | cemetery, c                  | position (Name of<br>rematory or other pla<br>ake Cremat |                                   | Date<br>8/02/07                                       |                           | ocation - City or T<br>tsville,       |   |  |
| 3alt                | permit. Departr Importa any Inju   |                 | 21. Signature of Fu   | ineral Service   | License                               | 4                                     |                              | 22. Name and Addr  | ess of Facility<br>Cremat         | tion Serv   | ice                       | P.O. Box                              | x 784   |  |
| VINCENTAL           | Physician<br>/Medical<br>Examiner  | J.C.            | Immediate Cause (<br>disease or condition<br>resulting in death)  | Ba. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Insease or condition sulting in death)  a. Due to (or as a consequence of):  The mode of Funding and Address of Facility Going Home Cremat Mo1251 Beverly L. Heckro  Ba. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.  Brain Alash.  Due to (or as a consequence of): |                                       |                                       |                              |  |                                   |   | a <b>rre</b> st,          | arksvill                              | Approximate Interval Between Onset and Death  |  |
| 68760,              | ificate be executed<br>g physician and<br>as the burial-transit  | edical Examiner | Sequentially list co<br>if any, leading to in<br>cause. Enter Unde<br>Cause (Disease or<br>that initiated events<br>resulting in death) I | 6  | C                                     |                                       | consequence of):             |  |                                   |   |                           |                                       |   |  |
| O. Box              | The law requires that the death certif<br>te has been signed by the attending<br>bage 2 should be detached for use as  | Physician/M     | IF FEMALE:<br>23b. Was deceden<br>in the past 12<br>1 ☐ Yes 2 ☐<br>9 ☐ Unknown  | months?<br>VNo   |                                       | birth 2<br>gnant at tir               | ☐ Fetal death                | 3 □Ectopic pregnanc<br>5 □ Other (specify) _             | у                                 |   |                           | 23d. Date of deliv<br>Month           | ery<br>Day Year                               |  |
| rds, P.             | w requires that<br>been signed b<br>should be deta   | ρ               | Part II. Other signif   |  | ions contributing to                  |                                       |                              | underlying cause gi                                      | ven in Part I.                    |   |                           |                                       | he cause of death?                            |  |
| or Vital Records,   | The law re<br>ate has bee<br>page 2 sho  | Completed       | Jyn   | dro  | uj                                    |                                       |                              |  |                                   | 24a. Wa:<br>auti<br>peri<br>1 Yes                     | opsy<br>formed?           | prior to co                           | opsy findings available impletion of cause of |  |
| ita                 | ysician: Th<br>is certificate<br>director, pag   | Be C            | 25. Was case refer examiner?  | red to medica  | al                                    |                                       |                              |  | 26. Place of                      | Death (Check only                                     |                           | 1 10163                               | 20140   |  |
| > >                 | dir di   | 10              | 1 Yes 200   | No   | Hospital: 1                           | Inpatient                             | 2 ER/Outpat                  | ient 3□ DOA Ot   | ner: 4 🗆 Nursir                   | ng Home 5□Res   | sidence                   | 6 ⊟Other (Speci                       | fy)   |  |
| n o                 | tending Pheath. tor: After the   |                 | 27. Manner of Deat  | th<br>5 ☐ Pendi  | /8.4-                                 | e of Injury<br>onth, Day              | (ear) 28b. Time              |  | ry at<br>rk?                      | 28d. Describe   | how injur                 | ry occurred                           |   |  |
| Division            | or Attending<br>after death.<br>Director: After<br>in by the fune  | Certification:  | 2 ☐ Accident<br>3 ☐ Suicide<br>4 ☐ Homicide   | 6 ☐ Could  | nined 286. Place                      | ce of injury<br>ding, etc.            |                              | M   1   street, factory, office                          | ]Yes 2∏No                         |   | (Street an                | nd Number or Rur<br>e)                | al Route Number,                              |  |
|                     | To the Hospital or Atte within 24 hours after dea To the Funeral Directo completely filled in by the   | Medical Ce      | 29a. Certifier<br>(Check only<br>one)   | 1 Certifyi<br>2 Medica   | I Examiner: On the                    | ne best of<br>basis of e              | xamination and/o             | eath occurred at the t<br>investigation, in my           | ime, date and p<br>opinion, death | place, and due to the occurred at the time            | e cause(s)<br>e, date and | ) and manner as a<br>d place, and due | stated.<br>to the cause(s)                    |  |
|                     | To the within Fo the complex c | Me              | 29b. Signature and  | title of certific  |                                       |                                       |                              | 29c. Licen   | se number                         |   | 29d. Da                   | te signed (Month,                     | Day, Year)                                    |  |
|                     | ~  |                 | f.a.  | RIU  | ua, M                                 | 2                                     |                              | 201  | 0654                              | 143   | 81                        | 01/07                                 | 7   |  |
| 6                   | 900  |                 | 30. Name and addr   | ress of persor   | who completed car                     | use of dea                            | th (Item 23a) (Typ           | e, Print)<br>even th                                     | Str                               | Frederi   | i                         | MD 2                                  | 1701  |  |
|                     | Sta<br>Registr   |                 | 31. Date filed (Mon   | oth, Day, Year   | 32.                                   | Registra                              | s Signature                  | Smil   | 217 1                             | 1 24877   |                           | .,,                                   | . , - 1                                       |  |
|                     | negisti  | u,              | 0/0//   | W THU  | וטעג פענו                             | 100                                   | BUL D                        | and)   | •                                 |   |                           |                                       |   |  |

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 28 Day 2007 Pritchett Gary Wayne 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Dord If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 1X M 2 □ F 220-52-8586 57 Feb. 17, 1950 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Hurlock Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21643 4417 Richard Way 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 □ Yes 2 🖺 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) printer publishing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Windsor Warren Houston Pritchett

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Preston

MD

21655

P. O. Box 539, Hurlock, MD 21643

Department of Health and Mental Hygiene. Important; If item 27 is marked other than "n any Injury or other traumatic event, the Mentionce. Physician /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

2

MD

19a. Informant's Name/Relationship (Type. Print)

wife

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tina Pritchett

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

attending physician and for use as the burial-transit ed by the a within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

The law requires that the death certificate be executed

To the Hospital or Attending

Division or Vital Records, P.O. Box 68760,

|                        | 20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  | 20b. Place of Disposition (Name of cemetery, crematory or other place)  Dorchester Mem. Park                     | i i   | - City or Town, State  |  |  |  |
|------------------------|---|--|---|--|--|--|--|
|                        | 21. Signatur of Funeral Service Licensee  | 22. Name and Address of Facility 700 Locust St.,   | Thomas Funeral H<br>Cambridge, MD 2                   | ome P.A.<br>1613   |  |  |  |
|                        | 23a. Patt. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line   | he death. Do not enter the mode of dying, such as ca   | ordiac or respiratory arrest,                         | Approximate<br>Interval Between  |  |  |  |
|                        | Immediate Cause (Final disease or condition resulting in death)  a. 5 Q UA Due to (or as a  | consequence of):   | norm of Ton   | Onset and Death  8 years   |  |  |  |
| Examiner               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events                               | consequence of):   |   |  |  |  |  |
| lical Exa              |   | consequence of):   |   |  |  |  |  |
| Physician/Medical      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown | P ☐ Fetal death 3 ☐ Ectopic pregnancy  |   | ate of delivery<br>onth Day Year   |  |  |  |
| y Ph                   | Part II. Other significant conditions contributing to death but   | not resulting in the underlying cause given in Part I.   | 23e. Did tobacco use con                              | stribute to the cause of death?  |  |  |  |
| d by                   |   |  | 1 X Yes 2 □ No  | 3 ☐ Probably 4 ☐ Unknown   |  |  |  |
| Completed              |   |  | 24a. Was an autopsy performed? 1  Yes 2 No            | Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ⋈ No |  |  |  |
| Be (                   | 25. Was case referred to medical examiner?  |  | f Death (Check only one)                              |  |  |  |  |
| ျ                      | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatien   | t 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 ☐ Nursi   | ing Home 5 ☐ Residence 6 ☐ Ot                         | her (Specify)  |  |  |  |
| ation:                 | 27. Manner of Death  1  | y   28b. Time of   28c. Injury at  | 28d. Describe how injury occu                         | rred   |  |  |  |
| Sertific               | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injur building, etc.  | ry - At home, farm, street, factory, office (Specify)  | 28f. Location (Street and Num<br>City or Town, State) | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)        |  |  |  |
| Medical Certification: |   | f my knowledge, death occurred at the time, date and pexamination and/or investigation, in my opinion, death ed. |   |  |  |  |  |
| Me                     | 29b. Signature and title of certifier   | 29c. License number 0 5 3 2 5 3  | /   | ed (Month, Day, Year)  |  |  |  |

State Registrar TIMOTH

31. Date filed (Month, Day

Day, Year)

MO

ar's Signature

Lednon

|  |   | 1 - State<br>Registrar   | (  | Certificate  | of Death  |  | g. No.   | 17 51:1   |
|--|---|--|--|--|---|--|--|---|
| Physici<br>/Medio<br>Examir  | cal   | 1. Decedent's Name (First, Middle, S  4a. Facility Name (If not institution, Cruhte Mexac  | E. Perini  | 4b. City, T  | own, or Location of Death   | 2. Date of Death<br>Month  | Day  | r   |
| Funeral<br>Director  |   | 5. Social Security Number  |  | vrs. last birthday) If Under 1 Months Yrs.   |   | 8. Date of Birth   | 1  | 9. Birthplace (State or Fo<br>Country)<br>New York  |
|  | ctor  | Usual Residence of Decedent  10a. State 10b. County  Maryland Wash   | ington 10c.  | City, Town or Location William   | msport  | Jun 20   | ,/14.3   | 10d. Inside City U  |
| 23g or 21  | al Dire   | 10e. Street and Number 15351 Delling   | er Road  | 10f. Zip C   | 21795   | 10   | g. Citizen of W  | /hat Country?   |
| it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23s or 28s-1 show or other traumatic event, it e Madical Examitment countries and or other traumatic event. | d by Funeral Director                               | 11. Marital Status 1 ☐ Never Married 2X Marrie 3 ☐ Widowed 4 ☐ Divorced  | 12. Was Decedent Ever in<br>Armed Forces?<br>1 ☐ Yes 2 (W No<br>If Yes, Give<br>Year or Dates:   | 1 □ Yes 2  |   |  | 14. Race<br>Black<br>Specify:  | e - American Indian,<br>k, White, etc.<br>· White   |
| ene.<br>than "nat<br>te Medic:   | Completed by  | 15. Decedent'<br>(Specify only highest<br>Elementary/Secondary (0-12)  | s Education<br>t grade completed)  College (1-4or 5+)  |  | done during most of work retired)   | ting   | l6b. Kind of Bu  | siness/Industry   |
| Hygiene.<br>othar thar<br>ent, It e It   | Be Con  | 12<br>17. Father's Name (First, Middle, L  |  | Construc   | tion Manage   | r<br>e (First, Middle, N   |  | uction Compa  |
| Mental   | To B  | Peter Perini   |  |  |   | a Marche   |  |   |
| saith and<br>n 27 is ma<br>ier trauma  |   | 19a. Informant's Name/Relationsh<br>Margaret A. Pe   |  |  | Street and Number or Rui<br>Linger Road 1   |  |  |   |
| nent of Hea<br>int: If item<br>iry or other  |   | 20a. Method of Disposition  1 XBurial 2 Cremation  | Date 2   | Oc. Location - (   | City or Town, State   |  |  |   |
| ne di ne   |   | <ul><li>4 □ Donation 5 □ Other (Sp</li><li>21. Signature of Funeral Service L</li></ul>  | pecify)  | Rose Hill Ceme   | Address of Facility Do  |  | _  | own Maryland  |
| Departr<br>Imports<br>any Inju   |   | Dunch.   | A Fine   | 12/24/12/12  | astern blvd   |  |  |   |
| nysician<br>Medical  |   | Immediate Cause (Final disease or condition  | Byan   | - 16   |   |  |  | Interval Between  |
| xaminer  | ner   | Sequentially list conditions, Tary, leading to mind date cause. Enter Underlying   | Due to (or as a cons   | sequence of):  | liublaston  | a Mul  | t: torn  | Onset and Dea   |
| ysician and<br>e burial-transit  | dical Examiner                                      | Sequentially list conditions.  I any, leading to initial discusse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (or as a cons   | sequence of):  | 1,0514560   | a mw   | t; torn  | Onset and Dea   |
| ysician and<br>e burial-transit  | cal   | Sequentially list conditions, I any, reading to mine diate cause. Enter Underlying Cause (Disease or injury that initiated events  | b. — Due to (or as a cons  | sequence of):  sequence of):  sequence of):  gnancy etal death 3 □Ectopic preg   | gnancy  | 2 MW   |  | Onset and Dea   |
| ysician and<br>e burial-transit  | by Physician/Medical                                | Sequentially list conditions.  Tany, reading to in modulate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  | Due to (or as a constitution of pression o | sequence of):  sequence of):  gnancy retal death 3 Dectopic pregored death 5 Other (spectors)  resulting in the underlying cau   | inancy<br>iffy)   | 23e. Did tob   | 23d. Date<br>Mon   | onset and Dea   |
| ysician and<br>e burial-transit  | by Physician/Medical                                | Sequentially list conditions. I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  Part II. Other significant condition | Due to (or as a constitution of pression of the pregnant at time of the pression of the pression of the pregnant at time of the pression of th | gnancy retail death 3 Dectopic pregoresulting in the underlying cau  | inancy<br>iffy)   | 23e. Did tob. 1 □ Ye: 24a. Was an  | 23d. Date Mon acco use contri  | onset and Dea   |
| ysician and<br>e burial-transit  | e Completed by Physician/Medical                    | Sequentially list conditions. I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  Part II. Other significant condition | Due to (or as a const.)  C   | gnancy retail death 3 Dectopic pregoresulting in the underlying cau  | inancy<br>hify)<br>use given in Part I.   | 23e. Did tob.  1  Ye:  24a. Was an autopsy perform 1  Yes 2  | 23d. Date Mon acco use contri s 2 \( \text{No} \) yed? All No 1  | of delivery th Day Year sibute to the cause of death 3 Probably 4 Onkr  |
| ysician and<br>e burial-transit  | Be Completed by Physician/Medical                   | Sequentially list conditions. I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown  Part II. Other significant condition | Due to (or as a const.)  C   | gnancy retail death 3 Dectopic pregoresulting in the underlying cau  | inancy<br>ify)<br>ise given in Part I.<br>26. Place of Deat                         | 23e. Did tob.  1  Ye.  24a. Was an autopy perform 1  Yes 2   | 23d. Date Mon acco use contributions 2 \( \text{No} \) No 24b. Wed?  | of delivery tith Day Year sibute to the cause of death 3 Probably 4 Onkr Were autopsy findings avarior to completion of cause ath? Yes 2 No |
| ysician and<br>e burial-transit  | To Be Completed by Physician/Medical                | Sequentially list conditions. Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | Due to (or as a constitution of the last o | sequence of):  sequence of):  gnancy etal death  | 26. Place of Deat Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No                    | 23e. Did tob.  1   | 23d. Date Mon acco use contri s 2 No 24b. W pl dd No 1 nce 6 Othe w injury occurre   | onset and Dea   |
| ysician and<br>e burial-transit  | Certification; To Be Completed by Physician/Medical | Sequentially list conditions.  Tany, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1                                 | Due to (or as a constitution of the last o | gnancy retal death 3 Ectopic preg of death 5 Other (spec  resulting in the underlying cau  c   | gnancy ify)  26. Place of Deat Other: 4 Nursing Ho cliniury at Work? 1   Yes 2   No | 23e. Did tob  1  | 23d. Date Mon  acco use contri s 2 \( \text{No} \)  24b. W  pi d2 \( \text{Pi} \)  nce 6 \( \text{Othe} \)  w injury occurre  eet and Numbe  State)                                  | onset and Dea   |
| ysician and<br>e burial-transit  | Certification; To Be Completed by Physician/Medical | Sequentially list conditions.  any, leading to him diatal cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  | Due to (or as a constitution of the last o | sequence of):  sequence of):  sequence of):  gnancy etal death 3   Ectopic preg etal death 5   Other (spec  resulting in the underlying cau  c                    2   ER/Outpatient 3   DOA  2   28b. Time of Injury M  at home, farm, street, factory, or  knowledge, death occurred at               | 26. Place of Deat Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No                    | 23e. Did tob.  1  Ye:  24a. Was an autopsy perform  1  Yes 2  h (Check only one sime 5 Resider 28d. Describe hor City or Town, | 23d. Date Mon  acco use contri s 2 No  24b. W pl dd No 11  20  20  20  20  20  20  20  20  20  | onset and Dea   |
| n.<br>After this certificate has been signed by the attending physician and<br>tuneral director, page 2 should be detached for use as the buriat-transit   | To Be Completed by Physician/Medical                | Sequentially list conditions.  Tany, reading to in miculate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1                              | Due to (or as a constitution of the last of the best of my lixaminer: On the basis of example.   | sequence of):  sequence of):  sequence of):  gnancy etal death 3   Ectopic preg of death 5   Other (spec  resulting in the underlying cau  2   ER/Outpatient 3   DOA  28b. Time of Injury M  At home, farm, street, factory, of secify)  knowledge, death occurred at ination and/or investigation, in | 26. Place of Deat Other: 4 Nursing Ho Injury at Work? 1 Yes 2 No                    | 23e. Did tob.  1   | 23d. Date Mon acco use contri s 2 \( \text{No} \) 24b. W pl di 11 n) nce 6 \( \text{Otherwise} \) one 4 \( \text{Otherwise} \) weet and Number State) use(s) and mar te and place, a | onset and Dea   |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2007 7:20P 31 July Emma Gertrude Parry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Caroline Caroline Nursing Home Denton If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Days **Funeral** Hours 1 M 2 XF Yrs. 1908 Pennsylvania 168-38-3791 99 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County f show the Medical Examiner must be notified at 1 X Yes 2 □ No Denton Maryland Caroline 28a-f Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 21629 USA 902 A Gay Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White Specify: 0 1 Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 X Widowed 4 □ Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) own home homemaker 08 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental 27 is marked c Ellen Treubler Trone George E. Trone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) : If Item 27 is or other tra 10660 Greensboro Road; Denton, MD 21629 Harold Parry/ son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Bethlehem Memorial Pk 8/6/07 Bethlehem, Penn Department Important: If any injury o 22. Name and Address of Facility permit. 21. Signature of Funeral Service Licenses Fleegle and Helfenbein Funeral Home, PA Maryland, Box 160; ne mode of dying, such as Greensboro, 23a. Part1. Enter the disease, or complications that coded the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a a onsequence of): Examiner 10101 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physiclan/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death P.O. detached 9□ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl. one Hospital: Other: 2 **N**o Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3 DOA 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient Medical Certification: To After this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 Natural To the most after death.
within 24 hours after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 92C 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

AUG 03

2007

|                     |  |                           | 1 - For<br>State<br>Registrar  | State of M   | laryland           |  | artmen<br>rtificate      |                        |                    | and M                 |                                      | giene<br>Reg. No.               | 107  | 25121  |
|---------------------|--|---------------------------|--|--|--------------------|--|--------------------------|------------------------|--------------------|-----------------------|--------------------------------------|---------------------------------|--|--|
| п                   | Physici  | an                        | Decedent's Name (First, Middle, Las  | it)  |                    |  |                          |                        |                    |                       | 2. Date of De<br>Month               | ath<br>Day                      | Year   | 3. Time of Death                                   |
|                     | Physici<br>/Medi   |                           | Richard Charles  | Reeser   |                    |  |                          |                        |                    |                       | 8                                    | 1 2                             | 007  | 12:32 P M  |
| 1                   | Examir   | ier                       | 4a. Facility Name (If not institution, give  |  |                    |  | 4b. City,                | Town, or               | Location o         | of Death              |                                      | 4c. Coun                        | ty of Death  |  |
|                     |  |                           | Atlantic General  5. Social Security Number 6. Secu |  |                    |  | Be:                      | rlin                   | If Under:          | OA Ura                |                                      |                                 | rcest  |  |
|                     | Funeral<br>Director  |                           |  | 12KM 2□F   | ge (In yrs. Ia     | Yrs.                                   |                          | Days                   | Hours              | Min.                  | 8. Date of Bir (Month, Da 3/15/1     | y, Year)<br>1937                | 9. Birth<br>Cou                                      | place (State or Foreign<br>intry)<br>PA            |
|                     | 72 hours after death with the Maryland<br>'naturel', or Iteme 23a or 28e-f ehow<br>dical Examinar must be recitified at  |                           | 10a. State 10b. County   |  | 10c. City          | , Town or Lo                           | cation                   |                        |                    |                       |                                      |                                 |  | 10d. Inside City Limits                            |
|                     | Mar.   | to                        | MD Worceste  | er   | В                  | erlin                                  |                          |                        |                    |                       |                                      |                                 |  | 1 ☐ Yes 20 No                                      |
|                     | er death with the Marylan<br>Iteme 23a or 28e-f ehow   | Director                  | 10e. Street and Number   |  |                    |  | 10f. Zip                 | Code                   |                    |                       |                                      | 10g. Citizen o                  | f What Cou   | intry?   |
|                     | ath w 23a  | raf                       | 43 Bramblewood I   | r.   |                    |  | 218                      | 311                    |                    |                       |                                      | USA                             |  |  |
|                     | er de  | Funeral                   | 11. Marital Status   | 12. Was Decedent<br>Armed Forces                             | ?                  | 3. 13. V                               | Nas Deced<br>f Yes, spec | ent of His             | spanic Orig        | gin? (Spe<br>, Puerto | cify Yes or No<br>Rican, etc.)       | - 14. Ra                        | ace - Ameri<br>ack, White                            | can Indian,<br>etc.                                |
| 36                  | rs afte  | by F                      | 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 ☐<br>If Yes, Give                                  | ₫No                | 1                                      | 1 □ Yes 2                |                        | Specify:           |                       |                                      |                                 | <sup>ify:</sup> Wh <b>i</b>                          |  |
| 윽                   | ture<br>sture  |                           | 15. Decedent's Ed  | Year or Dates:   |                    | 16a. Dece                              | lent's Heur              | I Occupa               | tion               |                       |                                      | 16b. Kind of                    |  |  |
| 15                  | 72 nin 72  | Completed                 | (Specify only highest gra-   | de completed)  | 5.)                | (Give                                  | kind of wor<br>DO NOT us | k done d<br>e retired) | u <i>ring</i> most | of worki              | ng                                   | 100. Kind of                    | Dusii iessyii  | loustry  |
| 212                 | d with   | E                         | Elementary/Secondary (0-12)  | College (1-4or<br>4  | 5+)                | Vice                                   | Pres                     | iden                   | t                  |                       |                                      | Sales                           | /Mark  | eting  |
| Maryland 21215-0036 | al Hyl   | Bec                       | 17. Father's Name (First, Middle, Last)  |  |                    |  |                          |                        | 18. Mothe          | r's Name              | (First, Middle,                      |                                 | ·  |  |
| <u>a</u>            | Menti<br>Menti<br>prked  | ဥ                         | Charles Reeser   |  |                    |  |                          |                        | Gert               | rude                  | Ya1e                                 |                                 |  |  |
| a                   | and and the man  |                           | 19a. Informant's Name/Relationship (7  |  |                    |  |                          |                        |                    |                       | l Route Numbe                        |                                 |  | o Code)  |
| <u>≥</u>            | and<br>leelth<br>m 27  | 35                        | Judith P. Reeser   | / wife   | 1200               | _                                      | -                        |                        | od Dr              |                       | erlin,                               |                                 |  |  |
| Baltimore,          | f of H   |                           | 20a. Method of Disposition 1 Deurial 2 Commation 3 D   | Removal from State   | Ce.                | ace of Dispo<br>metery, cren           | natory or ot             | her place              |                    |                       | ate                                  | 20c. Location                   | •  |  |
| Ë                   | tent:  |                           | 4 □Donation 5 □Other (Specify  |  | Cap                | e Hen                                  |                          |                        | i                  |                       | /2007                                | Frank                           |  |  |
| Bal                 | permit. Pages 1 and 2 should be filed within 72 hours afte Department of Heelth and Mental Hygiene. Importent: if I tem 27 is marked other than "naturel", or it enty injury or other treumatic event, the Medical Exercit 2005. |                           | 21. Signature of une el Service Licen  | Julas.   |                    | 1                                      |                          |                        |                    |                       | Burbag<br>erlin,                     | •                               |  | ome  |
|                     | Physician<br>/Medical<br>Examiner  | ner                       | 23a. Part 1. Enter the disease or companies, or heart tailure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  | a. Due to (or as   | ine.<br>a conseque | ence of):                              | er the mode              | e at dying             | , such as o        | cardiac o             | r respiratory ai                     | rest,                           |  | Approximate<br>Interval Between<br>Onset and Death |
| Box 68760,          | th certificate be executed<br>ending physician and<br>r use as the burial-transit  | Physician/Medicai Examine | 200. Was decedent pregnant   | c  | of pregnan         | cy                                     | Ectopic pre              |                        |                    |                       |                                      | 23d. D                          | ate of deliv   | ery  |
| P.O.<br>B           | It the death certific<br>by the attending p<br>tached for use as   | hysicia                   | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 4☐ Pregnant a<br>9☐ Unknown                                  |                    |  | Other (spe               |                        |                    |                       |                                      | М                               | lonth  | Day Year   |
| rds, F              | The law requires that the death certific lie has been signed by the atlending page 2 should be detached for use as l   | Ď                         | Part II. Other significant conditions co   | ntributing to death t  | out not result     | ting in the un                         | iderlying ca             | use give               | n in Part I.       |                       |                                      | obacco use cor<br>res 2 □ No    |  | he cause of death?<br>pably 4 @Onknown             |
|                     | n: The law r<br>icate has be<br>r, page 2 sh   | Completed                 |  |  |                    |  |                          |                        |                    |                       | 24a. Was<br>autop<br>perfor<br>1 Yes | sy<br>med?                      | Were auto<br>prior to co<br>death?<br>1 \(\sum Yes\) | ppsy findings available impletion of cause of      |
| ⋚                   | sicial<br>certificacto   | Be                        | 25. Was case referred to medical examiner?   | Hospital:  |                    |  | -                        | Other                  |                    |                       | Check only o                         |                                 |  |  |
| n of                | Attending Physician: r death. sctor: After this certification the funeral director.  | on: To                    | 1  Yes 2  No  27. Manny of Death 1  Natural 5  Pending   | 28a. Date of Inju<br>(Month, Da                              |                    | R/Outpatient<br>28b. Time of<br>Injury |                          | c. Injury              | 4 🗆 INUI           |                       | ne 5 Resid                           |                                 |  | (y)  |
| <u>s</u>            | ttend<br>death<br>stor: ,<br>the f   | cat                       | 2 Accident investigation 3 Suicide 6 Could not be  |  |                    |  | М                        |                        | es 2□N             |                       |                                      |                                 |  |  |
| Σ                   | itel or Al<br>irs after c<br>rel Direc<br>led in by  | Certification:            | 4 Homicide determined  |  | c. (Specify)       |  |                          |                        |                    |                       | City or Tow                          | n, State)                       |  | al Route Number,                                   |
|                     | To the Hospitel or Attending Physician: The within 24 hours after death. To the Funarel Director: Atter this certificate his completely filled in by the funeral director, page  | edical                    | 29a. Certifier 1 Cartifying Phy (Check only one) Medical Example 1 Medical Example 1   | sician: To the best<br>iner: On the basis o<br>and manner st | it examinatio      | ledge, death<br>on and/or inv          | estigation,              | in my opi              | nion, death        | place, a              | nd due to the o                      | ause(s) and m<br>date and place | anner as s<br>, and due to                           | tated.<br>o the cause(s)                           |
|                     | To the within 2 To the complet   | Σ                         | 29b. Signature and title of certifier  | <u></u>  |                    |  | 1                        | License                |                    |                       |                                      | 29d. Date sign                  | ed (Month,   | Day, Year)   |
|                     |  |                           | 1.MY   |  |                    |  | D                        | 534                    | 012                |                       |                                      | 8/2                             | 07   |  |
| В                   | A 10   |                           | 30. Name and address of person who of 9733 Health  | ompleted cause of c  | 0                  | f                                      | Print)                   | 2181                   | / A1               | ndre                  | a Baier                              | MD                              |  |  |
|                     | Sta<br>Registr   | te<br>ar                  | 31. Date filed (Month, Day, Year) AUG 0 2 20   | 07 32 legistr  | ar's Signaty       | -                                      | andles                   |                        | , 111              |                       | - DOTEI                              | 9 FID                           |  |  |

Richard C REESER DOB 5/1/07

|            |   |                  | 1 _ State   | State of Marylan                               |                               | artmen                                 |                     |                      | nd Me                                   |                                  | ene             | 17                       | 2 5 is 2                                     | ) -)                 |
|------------|---|------------------|---|--|-------------------------------|--|---------------------|----------------------|---|----------------------------------|-----------------|--------------------------|--|----------------------|
|            |   |                  | Registrer  1. Decedent's Name (First, Middle, Last)                               |  |                               | moun                                   | 0. 2                |                      | 2                                       | 2. Date of Death                 | -               | ,                        | 3. Time of D                                 | eath                 |
| +3         | Physicia  | an               | Margaret Vincent  | Poddia   |                               |  |                     |                      |   | Month<br>August 2                | Day 2007        | Year<br>7                | 5:07   | рΜ                   |
|            | /Medic<br>Examin  | , a i            | 4a. Facility Name (If not institution, give st                                    |  |                               | 4b. City,                              | Town, or            | Location of          |   | lugust 2                         | 4c. County      |                          | J.01   | _ <del>_</del>       |
|            | LAdimii   |                  | Homewood At William   | sport  |                               | Will                                   | iams                | port                 |   |                                  | Wash            | ingto                    | n  |                      |
|            | Funeral   |                  | 5. Social Security Number 6. Sex  | 7. Age (In yrs. I                              |                               | If Under<br>Months                     |                     | If Under 2<br>Hours  | Min.                                    | B. Date of Birth<br>(Month, Day, | Year)           | 9. Birtho                | place (State or I                            | Foreign              |
| 187        | Director  |                  | 217-12-2494   | M 201 84                                       | Yrs.                          |  |                     |                      |   | July 15                          |                 | West                     | Virgir                                       | nia                  |
|            | pur *   |                  | Usual Residence of Decedent  10a. State 10b. County                               | 10c. City                                      | , Town or Lo                  | ocation                                |                     |                      |   |                                  |                 | 1                        | 0d. Inside City                              | Limits               |
|            | Aaryli<br>f sho   | 5                | M 1 1 - 17 1 - 4 4 4  | 7.74.1.1                                       |                               |  |                     |                      |   |                                  |                 |                          | 1 Tes 2                                      | 2 🗀                  |
|            | 28a-  | ect              | Maryland Washington 10e. Street and Number  | 1 WIII   | iamspo                        | 10f. Zip                               | Code                |                      |   | 10                               | g. Citizen of \ | What Cour                | ntry?  |                      |
|            | hours after death with the Maryland<br>tural, or tleme 23a or 28a-f show<br>al Examinat must be rudilled at   | Funeral Director | 16505 Virginia Ave  |  |                               | 217                                    | 795                 |                      |   |                                  | U.S.A           |                          |  |                      |
|            | death<br>me 2   | nera             |   | 2. Was Decedent Ever in U.<br>Armed Forces?    | S. 13.                        | Was Deced                              | dent of Hi          | spanic Orig          | gin? (Spec                              | ify Yes or No-                   |                 | e - Americ<br>ck, White, | can Indian,                                  |                      |
| 9          | after<br>or Ite   | Ē                | 1 Never Married 2 Married   | 1 Yes 2 No                                     |                               | 1  Yes                                 |                     | Specify:             | , | ,                                | Specif          |                          | 0.0.   |                      |
| 21215-0036 | ural',  | d by             | 3 Widowed 4 □ Divorced  | Year or Dates:                                 |                               |  |                     |                      |   |                                  |                 | Whi                      |  |                      |
| 5-         | natu  | Completed        | 15. Decedent's Educ<br>(Specify only highest grade                                | ation<br>completed)                            | (Give                         | dent's Usua<br>kind of wo<br>DO NOT us | rk done d           | during most          | of working                              | 9                                | 6b. Kind of B   | usiness/in               | dustry                                       |                      |
| 121        | within<br>ene.<br>than "  | ф                | Elementary/Secondary (0-12)   | College (1-4or 5+)                             | Homen                         |  | 30 701700           | /                    |   |                                  | Domes           | stic                     |  |                      |
| d 2        | filed with<br>Hygiene.<br>other than  |                  | 17. Father's Name (First, Middle, Last)   |  | Homen                         | Idkei                                  |                     | 18. Mothe            | r's Name                                | (First, Middle, M                |                 |                          |  |                      |
| an         | ould be<br>Mental<br>Marked o   | To Be            | William Hamilton Mo   | rrow   |                               |  |                     | Riek                 | ra Fd                                   | na Lick                          | lidor           |                          |  |                      |
| Maryland   | 2 should and Men is marke sumatic   | -                | 19a. Informant's Name/Relationship (Typ   |  | 19b. Maili                    | ng Address                             | (Street a           |                      |   | Route Number,                    |                 | State, Zip               | Code)  |                      |
|            | s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene the Protection of Item 27 is marked other than "natural", or Iteme 23a or 28a-f show then traumatic avent, The Medical Examinat must be incitified at |                  | Barbara M. Mumma /  | Daughter                                       | 76 N                          | lorth                                  | Edge                | boows                | Driv                                    | e Hager                          | stown I         | Mary1                    | and 217                                      | 740                  |
| Ĵ.         |   |                  | 20a. Method of Disposition  | 20b. P   | lace of Dispo<br>emetery, cre | osition (Nar                           | me of<br>other plac | (8)                  | Da                                      | ite 2                            | Oc. Location    | City or T                | own, State                                   |                      |
| Ë          | Pages<br>nent of h<br>ant: If Its<br>ury or o   |                  | Burial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)                   | Res  | t Have                        | en Cen                                 | neter               | cy 8                 | 3/8/2                                   | 007 H                            | agerst          | own,                     | Marylar                                      | nd                   |
| Baltimore, | permit. Page<br>Department o<br>Important: If<br>any Injury or<br>once.   |                  | 21. Signature of uneral Service Lice  | 7  | 2:                            | 2. Name ar                             | nd Addres           | ss of Facility       | <sup>y</sup> Rest                       | Haven :                          | Funera          | 1 Cha                    | pe1  |                      |
| <u>m</u>   | 8988  |                  | 12 113  | ~~~  | $\sim$ 16                     | 01 Pe                                  | ennsy               | /lvani               | ia Av                                   | e Hager                          | stown 1         |                          | and 217                                      |                      |
| 15         |   |                  | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one | ations that caused the deat                    |                               | /                                      | . /                 | _                    |   | respiratory arre                 | st,             |                          | Approximate<br>Interval Betw<br>Onset and De | /een                 |
|            | Physician   |                  | Immediate Cause (Final disease or condition                                       | Codio  | echsc                         | ulo                                    | H SC                | Tife                 | 0                                       |                                  |                 |                          | Pas  |                      |
|            | /Medical<br>Examiner  |                  | resulting in death)   | Due to (or as a conseq                         | uence of):                    |  |                     |                      |   |                                  |                 | (                        |  |                      |
| н          | LAditiniei  | L.               | Sequentially list conditions.   | Due to (or as a conseq                         |                               |  |                     |                      |   |                                  |                 |                          |  |                      |
|            | pe sit  | lne              | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury     | D04 to (or as a conseq                         | derice or,                    |  |                     |                      |   |                                  |                 |                          |  |                      |
|            | and al-trar   | Examiner         | that initiated events c. resulting in death) Last                                 | Due to (or as a conseq                         | uence of):                    |  |                     |                      | _                                       |                                  |                 | -                        |  |                      |
| 760        | The law requires that the death certificate be executed at the been signed by the attending physicien and page 2 should be detached for use as the buriat-transit   | CalE             |   |  |                               |  |                     |                      |   |                                  |                 |                          |  |                      |
| 687        | tificate<br>ng phys<br>as the   |                  |   |  |                               |  |                     |                      |   |                                  |                 |                          |  |                      |
| Box        | nding<br>use a  | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant 23  | c. If yes, outcome of pregna                   |                               | □Fatasia a                             |                     |                      |   |                                  |                 | ate of deliv             |  |                      |
|            | death<br>e atte   | <u>S</u>         | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  | 1 Live birth 2 Feta                            |                               | □Ectopic p<br>□ Other (s <sub>i</sub>  |                     |                      |   |                                  | М               | onth                     | Day Y  | ear                  |
| P.0        | that the death cer<br>ed by the attendir<br>detached for use  | hys              | 9 Unknown   | 9□ Unknown                                     |                               |  |                     |                      |   | 1                                |                 |                          | _  |                      |
|            | signed to   |                  | Part II. Other significant conditions con   | ributing to death but not res                  | ulting in the t               | underlying o                           | cause giv           | en in Part I.        | •                                       |                                  |                 |                          | the cause of de                              |                      |
| ğ          | w require<br>been sig   | bed              | AVIAL FEBRUIA   | 04   |                               |  |                     |                      |   | 1 ☐ Ye                           | s 2□No          | 3∐ Pro                   | babiy 4 ∐U                                   | nknown               |
| Records,   | law re<br>as be<br>2 sho  | Completed by     | Hypertension  |  |                               |  |                     |                      |   | 24a. Was ar<br>autops            | y               | prior to co              | opsy findings a<br>ompletion of ca           | ivailable<br>tuse of |
| æ          | The<br>ate h<br>page  | P                | Chapuse Israli  | e disa   | ce                            |  |                     |                      |   | perform<br>1 ☐ Yes 2             | ned?            | death?<br>1 ☐ Yes        | 2 □ No                                       |                      |
| Vital      | stan:<br>artific<br>ector,  | Be (             | 25. Was case referred to medical examiner?  |  |                               |  |                     |                      | of Death                                | (Check only on                   | 9)              |                          |  |                      |
| of \       | ding Physician: The lav<br>h.<br>After this certificate has<br>funeral director, page 2   | 2                | 1 ☐ Yes 2 No  |  | ER/Outpatie                   |  |                     | 4 Nu                 | irsing Hon                              |                                  | nce 6 □Ot       |                          | ify)   |                      |
| Ē          | ing P   | on:              | 27. Manner of Death  1 Natural 5 □ Pending  | 28a. Date of Injury<br>(Month, Day Year)       | 28b. Time o<br>Injury         | of M                                   | 28c. Injur<br>Wor   | yat<br>k?<br>Yes 2 □ |   | 8d. Describe ho                  | w injury occu   | rred                     |  |                      |
| Division   | Attending r death. ector: After by the fune   | Certification:   | 2 Accident investigation 3 Suicide 6 Could not be                                 | 28e. Place of Injury - At h                    | ome farm s                    |  |                     | 162 2 🗆              |   | 8f. Location (St                 | reet and Num    | ber or Ru                | ral Route Numb                               | ber.                 |
| ĬŽ         | or At<br>after<br>Direct<br>in by   | artif            | 4 Homicide determined   | building, etc. (Special                        | (y)                           | 11001, 120101                          | iy, onice           |                      |   | City or Towr                     |                 |                          |  | ,                    |
|            | pital   |                  | 29a. Certifier 1 Certifying Phys  | ician: To the best of my kno                   | owledge, dea                  | ith occurred                           | d at the tir        | me, date an          | nd place, a                             | and due to the ca                | ause(s) and m   | nanner as                | stated.                                      |                      |
|            | 24 h  | edical           |   | er: On the basis of examina and manner stated. |                               |  |                     |                      |   |                                  |                 |                          |  | 1                    |
|            | To the Hospital or Attendir<br>within 24 hours after death.<br>To the Funeral Director: Al<br>completely filled in by the fu  | ₩                | 29b. Signature and title of centifier   |  |                               | 29                                     | c. Licens           | e number             |   | 2                                | 9d. Date sign   | ed (Month                | , Day, Year)                                 |                      |
|            |   |                  | 1////   |  |                               |  | 12                  | 680                  | 26                                      | 6-                               | lyur            | -3.                      | 200  | >                    |
|            |   |                  | 30. Name and address of person who co   | mpleted cause of death (Iter                   | п 23а) (Туре                  | Print)                                 |                     | -                    | ,                                       | A.                               | 1               |                          | . 1  | 1 16                 |
| 0          | グイース  |                  | Alten W. D.   | HO, MD   | 13L                           | 194                                    | Her                 | nsy                  | lyan                                    | 1a AVO                           | ·Ha             | gers                     | stown  | M                    |
| 3.5        | St.<br>Regist   | ate              | 31. Date filed (MonA.U.G 10-17) 20  | 32. Fegistrar's Sign                           | ature                         | La. K                                  | ,                   | ŕ                    |   |                                  |                 | )                        | <u>ال</u>                                    | 746                  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** July 28 2007 10:30 PM Μ. Rose, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot Genesis HealthCare - The Pines Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1**⅓**M 2□F 183-14-0331 90 Yrs. Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits show 1 □xYes 2 □ No Director Easton MD Talbot 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code s 23a or 26101 United States 201 Federal Street Apt. 57 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. other than "natural", or items 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐XNo Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Sales 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hient: If itsm 27 is marked other: John M. Rose, Sr. Maude Lansdale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
importent: if itsm 27 is
any injury or other trau
once. 201 Federal St., Apt. 57, Easton, MD 21601 Claire L. Rose/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Removal from State Cambridge, Maryland Mid-Shore Crem. Ctr. 07/31/07 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 216 N. Main St., Federalsburg, ND 21632 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospitel or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 2 🗆 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an cete has I performed? this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No After this certification, funeral director, 25. Was case referred to medical 26. Place of Death Check only one examiner' Hospital: Other: 4 Thursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ M6 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Anatural 5 Pending investigation 1 ☐ Yes 2 ☐ No М Director: 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 1 Partifying Physician: To the best of my knowledge death occurred at the time, date and time to the newse(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number who completed cause of death (Item 23a) (Type, Print) ROBINS CIVIC AVENUE LLIAM 31. Date filed (Month egistrar's Signatu State

DHMH 17 Rev 1/2001

Registrar

| 07-05964 |
|----------|
|----------|

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

| Physician/<br>I Examiner   | Decedent's Name (First, Middle,Last)   | 2. Date of Death   |   |
|--|--|--|---|
|  | Michael D. Schott  4a. Facility Name (if not institution, give street and number)  4b. Ci  | Month<br>August 4, 2   |   |
|  | Pleasure Island Cove Sp  | parrows Point  | Baltimore County  |
| uneral<br>Pirector   | 5 ( )  |  | n(MM/DD/YYYY) 9. Birthplace (State or Foreign<br>17,1973 <sup>Country</sup> Pennsylva |
| show any ce.   | 10a. State 10b. County 10c. City, Town or Location   | EllicottCity   | 10d. Inside City Limits 1 Yes 2 X No  |
| 23a or 28a-f show notified at once.  | 10e. Street and Number 10f 8854 Papillon Drive   | . Zip Code   | g. Citizen of What Country?   |
| penint rages a rang a short of the control of the c | 11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No  | cedent of Hispanic Origin? (Specify Yes or No-<br>pecify Cuban, Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc.  Specify: White                        |
| "natural",<br>al Examiner<br>eted by   | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Us   | 2 X No specify: sual Occupation (Give kind of work done working life. DO NOT use retired)    | 16b. Kind of Business/Industry  |
| Hygiene.  4 other than "nature of other than "nature of other than "nature of other other of other of other of other of other of other of other of other of other of other of other of other of other of other other of other other of other oth | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name (First, Middle, M  | ·   |
| d Mental ]<br>s marked<br>ic event,  |  | Beverly Fur ress (Street and Number or Rural Route Num                                       | ber, City or Town, State, Zip Code)   |
| F Health and Fitem 27 is er traumat  |  | addock Drive N. Hu (Name of cemetery, Date ace)  | ntingdon, PA. 15642   |
| partment of portant: Il jury or othe   | 4 Donation 5 Other Specify Irwin Uni   | on Cemetery 8-9-07   | Irwin,Pennsylvania  |
| /sician  | 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the me failure. List only one cause on each line.   | a Harrord Road, Ba   | est, shock, or heart Approximate Interv<br>Between Onset and                          |
| aminer   | Immediate Cause (Final disease or condition resulting in death)  Head Injuries complicated by drowning Due to (or as a consequence of):  | ]  | Death   |
| nsit Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated   |  |   |
| and - transit  | events resulting in death) Last  Due to (or as a consequence of):  d.  |  |   |
| Infrary requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial. Irransi Completed by Physician/Medical E)   | UNPENDED  AMENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal december 12 months?                          | eath 3 Ectopic pregnancy   | 23d. Date of delivery  Month Day Year   |
| by the attence ched for use  |  | (Specify)  Iving cause given in Part I. 23e. Did to  | bacco use contribute to the cause of death?   |
| en signed build be deta  |  |  | 2 No 3 Probably 4 Unknown   |
| ficate has been significate has been significate has been significate has been significant beautiful points.   |  | autop<br>perfor<br>1 ✔ Yes   | sy prior to completion of cause of med? death?  |
| this certificate<br>I director, page<br>To Be Con  | 25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3  | 26.Place of Death (Check only one)  DOA Other War Nursing Home 5                             | Residence 6 Other: Scene  |
| ours are death  eral Director: After this filled in by the funeral dir  Certification: To  | 27. Manner of Death 1 Natural 5 Pending FOUND: 2 ✓ Accident Investigation 2 128a. Date of Injury FOUND: 4 COUND: Aug 4, 2007 C0223 hrs   |  | now injury occurred<br>cted from boat   |
| our no spin or accenture russistant.  To the Funeral Director: After this certificompletely filled in by the funeral director,  ledical Certification: To Be C   | 3 Suicide 6 Could not be determined (Specify) Bay  | or Town, S<br>Pleasure Islan   | d Cove, Sparrows Point, MD  |
| vithin 24 ho<br>To the Fune<br>completely f  | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a cone)  2 Medical Examiner: On the basis of examination and/or investigation, and manner stated. | in my opinion, death occurred at the time, date  | and place, and due to the cause(s)  |
| Σ  | 29b. Signature and title of certifier  OuteT2  | 29c. License number O.C.M.E.   | 29d. Date signed (Month, Day, Year) August 4, 2007                                    |
| 12   | Mr. r.   | et, Baltimore, MD 21201  |   |
| State  | 31. Date filed (Month, Day, Year) 22. Registrar's Signature AUG 1 6 2007   |  |   |

|   |                | 1 - For State Registrar  |   | State of   | Maryland                              |                                  | rtment of<br>tificate of           |                               |                               |                                     | giene<br>Rag. No.                   | - Control of the Cont | 25425                                       |  |
|---|----------------|--|---|--|---------------------------------------|----------------------------------|------------------------------------|-------------------------------|-------------------------------|-------------------------------------|-------------------------------------|--|---|--|
|   |                | 1. Decedent's Name (First, Middle, Last)   |   |  |                                       |                                  |                                    |                               |                               | Date of De                          | ath                                 |  | 3. Time of Death                            |  |
| Physi<br>/Med   |                | HELEN H.   | SANDERS                                 | S  |                                       |                                  |                                    |                               | P                             | Month<br>INGUS                      | Day                                 | 2007   | 8:36AM                                      |  |
| Exam  |                |  |   |  |                                       |                                  |                                    |                               |                               |                                     | ounty of Death                      | Red  |   |  |
| Funera<br>Directo   |                | 5. Social Security Num<br>212–24–871   |   | х 7<br>Эм 2 <b>X</b> F                           | . Age (In yrs. I                      | ast birthday)<br>Yrs.            | If Under 1 Yea<br>Months Day       |                               | Min. 9                        | Date of Bin<br>(Month, Da<br>/22/19 | h<br>y, Year)<br>918                | Cour   | place (State or Foreign<br>ntry)<br>yland   |  |
| pu ,  |                | Usual Residence of De  |   |  | 100 City                              | Town order                       |                                    |                               |                               |                                     |                                     |  |   |  |
| anyla<br>shov   | 7              | 10a. State 1   | 0b. County                              |  |                                       | r, Town or Loc                   | ation                              |                               |                               |                                     |                                     | 1  | 10d. Inside City Limits 1 ☐ Yes 2X No       |  |
| the h   | Director       | 10e. Street and Numb   | York                                    |  | De.                                   | lta                              | 10f. Zip Code                      |                               |                               |                                     | 10g. Citize                         | n of What Cour   |   |  |
| 3a or   | Ö              | 250 Doo1   |   |  |                                       |                                  | 17314                              |                               |                               |                                     | -                                   | JSA  |   |  |
| death   | Funerai        | 11. Marital Status   |   | 12. Was Deced<br>Armed Ford                      | ent Ever in U.                        | S. 13. W                         | as Decedent of<br>Yes, specify Cu  | Hispanic Or                   | rigin? (Specif                | y Yes or No                         | - 14.                               | Race - Americ<br>Black, White,   |   |  |
| (1215-0036<br>within 72 hours after death with the Maryland<br>than "natural", or items 23a or 28a-f show<br>in Medical Examinat mast be notified at  |                | 1 Never Married  |   | 1 DYes 2   | X No                                  |                                  | Tes, specify Co                    |                               |                               | an, etc.)                           |                                     | pecify: Whi  |   |  |
| 15-003<br>172 hours<br>*natural;  | ted            | 15   | 5. Decedent's Edu                       | cation   |                                       | 16a. Deced                       | ent's Usual Occ                    | upation                       |                               |                                     | 16b. Kind                           | of Business/In   | dustry                                      |  |
| 21.5 Fig. 7   | Completed by   | (Specify Elementary/Second   | only highest grad<br>ary (0-12)         | Coltege (1-4                                     | for 5+)                               | life. D                          | ind of work don<br>O NOT use reti  | red)<br>red)                  | st of working                 |                                     |                                     |  |   |  |
| d 21<br>d 21<br>filed wi<br>Hygien<br>ent, the  | S              | 12   |   |  |                                       | Ins                              | spector                            | 10 11-11                      |                               | *                                   |                                     | ernment  |   |  |
| If SAUDERS  re, Maryland 21215-0  s 1 and 2 should be filed within 72 hr fleatin and Mental Hygiene. Item 27 is marked other than 'nature other traumatic event, the Medical                            | Be             | 17. Father's Name (Fit   | rsı, <i>middi</i> e, Lası)<br>P. Haines | •  |                                       |                                  |                                    |                               | er's Name (F                  |                                     | Maiden Su                           | imame)   |   |  |
| Should Me   | 2              | 19a. Informant's Nam   |   |  |                                       | 19b. Mailing                     | Address (Stre                      |                               | ena C.<br>per or Rural F      |                                     | er, City or T                       | own, State, Zip  | Code)                                       |  |
| M. Mand 2 and 2 sealth a m 27 is  |                | Dorothy E  | . Sander                                | s/Daugh  | ter                                   | 250 I                            | ooley R                            | Road, I                       | Delta,                        | PA 1                                | 7314                                |  |   |  |
| imore, I<br>Pages 1 and<br>nent of Healt<br>ant: If Item 2  |                | 20a. Method of Dispos  |   | Ramoval from St                                  | ata CE                                | emetery, crem                    | ition (Name of<br>atory or other p |                               | Date                          |                                     | 20c. Location - City or Town, State |  |   |  |
| Baltimore, Maryland 21215-0036 Spartment Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiene. In my Injury or other traumatic event, the Medical Example          |                | 4 □Donation 5  | Other (Specify,                         |  | Evar                                  |                                  | e Crema                            |                               |                               | 007                                 | Leo1                                | a, PA  |   |  |
| Baltimore, Maryland 2121 Benit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other traumatic event, traumatic |                | 21. Signature of Fune  | raf Service Licens                      | " fir  | len                                   | 15/                              | Name and Add<br>Kins Fu            |                               | •                             | Inc.,                               | Delt                                | a, PA  | 17314                                       |  |
|   |                | 23a. Part1. Emerune<br>shock, or heart f   | disease, or comp                        | lications that cau                               | used the death                        | Do not ente                      | r the mode of d                    | ying, such as                 | s cardiac or re               | espiratory ai                       | rest,                               |  | Approximate<br>Interval Between             |  |
| Physicia  |                | Immediate Cause (Fir disease or condition  |   | Ph   | Pum                                   | 0 1 -                            |                                    |                               |                               |                                     |                                     |  | Onset and Death                             |  |
| /Medica<br>Examine  |                | resulting in death)  |   | Due to (or                                       | r as a consequ                        |                                  |                                    |                               |                               |                                     |                                     |  |   |  |
|   | e e            | Sequentially list condi  | itions,                                 | b. Due to (or                                    | гая а соляжую                         | ience of):                       |                                    |                               |                               |                                     |                                     |  |   |  |
| be be start ansit   | Examin         | Sequentially list condi-<br>dany, leading to inin-<br>cause. Enter Underly<br>Cause (Disease or inji-<br>that initiated events | ing<br>ury                              |  |                                       |                                  |                                    |                               |                               |                                     |                                     |  |   |  |
| 68760, free ficate be executed physicien and s the burial-transit   | Exa            | resulting in death) Las  | st                                      | Due to (or                                       | r as a consequ                        | ience of):                       |                                    |                               |                               |                                     |                                     |  |   |  |
| 18760, cate be exphysicien a  | dical          |  |   | d  |                                       |                                  | _                                  |                               |                               |                                     |                                     | -  | _   |  |
|   | /Med           | IF FEMALE:   |   | 23c. If yes, outco                               | ome of pregnar                        | ncv                              |                                    |                               |                               |                                     |                                     |  |   |  |
| Box ( leath certif  | cian           | in the past 12 mg  | onths?                                  | 1 Live birt                                      | th 2 ☐ Fetal                          | death 3□I                        | Ectopic pregnar<br>Other (specify) |                               |                               |                                     | 230                                 | d. Date of delive<br>Month   | ery<br>Day Year                             |  |
| o.O.  | Physician/Me   | 1 Yes 2 N<br>9 Unknown   | 40                                      | 9□ Unknow  | m .                                   |                                  |                                    |                               |                               |                                     |                                     |  |   |  |
| S, F<br>es tha<br>igned<br>be dei   | by P           | Part ff. Other significa   | ant conditions co                       | ntributing to dea                                | th but not resu                       | ilting in the un                 | derlying cause o                   | given in Part I               | I.                            |                                     |                                     |  | ne cause of death?                          |  |
| Cord<br>w requir<br>been si   | ted            | - Januar   | re to                                   | thri   | ve                                    |                                  |                                    |                               |                               | 10                                  | res 2                               | 3 ☐ Prob   | oably 4 Unknown                             |  |
| Ae la has   | Completed      | Pemen  | tia                                     |  |                                       | -                                |                                    | · - · · -                     |                               | 24a. Was<br>autop<br>perfo          | an 2<br>sy<br>rmed?                 | death?   | psy findings available mpletion of cause of |  |
| Vital F<br>vicien: Th<br>certificate  | 0              | 25. Was case referred  | to medical                              |  |                                       |                                  |                                    | 26 Place                      | e of Death (C                 | 1□ Yes                              | 2. No                               | 1 🗌 Yes  | 2□ No                                       |  |
| f Vi<br>nysici<br>nis cer<br>direc  | To B           | examiner?  | 5                                       | Hospital: 1 ☐ fnp                                | patient 2 1                           | ER/Outpatient                    | 3□ DOA C                           | thor                          | /                             |                                     |                                     | Other (Specif  | iy)   |  |
| On Of<br>ding Ph<br>h.<br>After th<br>funeral   |                | 27. Manner of Death  | 5 Pending                               | 28a. Date of (Month,                             | Injury<br>Day Year)                   | 28b. Time of<br>Injury           | 28c. In                            |                               |                               | d. Describe I                       | now injury o                        | occurred   |   |  |
| isio<br>ttendi<br>death.<br>tor: A  | cati           | 2 Accident   | investigation<br>6 Could not be         | ORa Place  | f laines de ba                        |                                  |                                    | Yes 2                         |                               | Landing (                           | 244                                 |  |   |  |
| Divi  | Certification; | 4 Homicide   | determined                              | 286. Place o                                     | r injury - At no.<br>g, etc. (Specify | me, tarm, stre                   | et, factory, offic                 | Ө                             | 281                           | City or Tov                         | otreet and M<br>vn. State)          | Number or Hura   | al Route Number,                            |  |
| Divisir To the Hospital or Attentivities 24 hours after dealt   | Medical (      | 29a. Certifier 15<br>(Check only 25<br>one)  | Certifying Phy Medical Exam             | sician: To the b<br>ner: On the bas<br>and manne | is of examinat                        | wiedge, death<br>ion and/or inve | occurred at the estigation, in my  | time, date ar<br>opinion, dea | nd place, and<br>ath occurred | d due to the<br>at the time,        | cause(s) an<br>date and pla         | nd manner as s<br>ace, and due to  | tated. the cause(s)                         |  |
| To the within 2 To the complet  | Me             | 29b. Signature and titl  | e of certifier                          | 1  |                                       |                                  | 29c. Lice                          | nse number                    |                               |                                     | 29d. Date s                         | signed (Month,   | Day, Year)                                  |  |
|   |                | → ~  | Ramu                                    | 1 MG   | V_                                    | no                               | D                                  | 194                           | 73                            |                                     | Aua                                 | ust 1  | 1 2002                                      |  |
| le  |                | 30. Name and address   | s of person who c                       | ompleted cause                                   | of death (Item                        | 23a) (Type, F                    | 'rint)                             | 2 lar                         | N St                          | reet.                               | 1                                   | bende  | en  |  |
|   | itate          | 31. Date filed (Month,   | Day, Year)                              | 32 Rec   | gistrar's Signat                      | ture                             |                                    | ^                             | vary                          | and                                 | -21                                 | 100  | /   |  |
| Regis   |                | AU   | G 1 6 200                               | 17 3   | un B                                  | Loc                              | 20                                 |                               | ,                             |                                     |                                     |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Year 0630 A M Alan Emerson Stetson August 12 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Hospital E1kton Cecil If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Director 032-10-2352 86 DEC 22, 1920 Massachusetts Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Intent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 25a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2934 Singerly Road 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? World 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 M Yes 2 No World
If Yes, Give War II
Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 📉 No Specify. Completed by Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) County Road Inspector County Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dana Stetson ပို Henrietta Weber 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth E. Stetson/Wife 2934 Singerly Road, Elkton, Maryland 21921 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cherry Hill
Methodist Cemetery 20a. Method of Disposition 20c. Location - City or Town, State August 14, 1 X Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 2007 Cherry Hill, Maryland 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Sign, ture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1wk neumonio /Medical Due to (or as a consequence of): **Examiner** Heheimer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed ician and burial-trar Due to (or as a consequence of): Physician/Medical the attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Ne 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed 2 🗔 Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Mann 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Matural hours after death.

uneral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral D Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 044716 and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

AUG 1 6

2007

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760, 2

5+

Elkton,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 23e per loc 8871 9-20-07 vt.
State of Marviand / Bepartment of Health and Mental Hygiene

|  |  |                   | 1 - State Registrar  | Ce   | rtificate of   |  | , ,   | eg. No.2 UU /                                  |  |
|--|--|-------------------|--|--|--|--|---|--|--|
| Н  | Physici  | an                | Decedent's Name (First, Middle, Last)  IJATTACE  | WILSON   | CTIADT   | JR.  | 2. Date of Deat<br>Month                    | Day Year                                       | 3. Time of Death                                 |
|  | /Medic   |                   | WALLACE  4a. Facility Name (If not institution, give street and  |  | STUART  4b. City, Town, o  | r Location of Death                              | 08  | 10 07<br>4c. County of Dea                     | 2140   |
|  | Examin   | ici               | WMHS BRADDOCK CAMP   | US   | CUMBER   |  |   | ALLEGAN  | ď  |
|  | Funeral<br>Director  |                   | 5. Social Security Number 212-48-7942  Usual Residence of Decedent   | 7. Age (In yrs. last birthday,   | Months Days  | If Under 24 Hrs.<br>Hours Min.                   | 8. Date of Birth<br>(Month, Day,<br>Nov 23, | Year) 9. Bir<br>1946                           | thplace (State or Foreign<br>ountry)             |
| yland  | at   |                   | 10a. State 10b. County   | 10c. Cify, Town or L   |  |  |   |  | 10d. Inside City Limits                          |
| e Mar  | Ba-f sh<br>tiffied   | ctor              | WV Hampshire   | Spri   | ngfield  |  |   |  | 1 □Yes x²□No                                     |
| th with th   | 23a or 24<br>ist be no   | Funeral Director  | 10e. Street and Number P.O. Box 174  |  | 10f. Zip Code  | 26763  | 1   | 0g. Citizen of What C                          | ountry?  |
| er dea   | items<br>ner mu  | uner              | Armed  | ecedent Ever in U.S. 13. Forces?   | Was Decedent of H<br>If Yes, specify Cub                         | lispanic Origin? (Sp<br>an, Mexican, Puerto      | ecify Yes or No-<br>Rican, etc.)            | 14. Race - Am<br>Black, Whi                    |  |
| urs afte   | al",or≀<br>xamir   | by                |  | es 2 □ No<br>Give<br>r Dates: Vietnam  | 1 ☐ Yes 2 ☐ No   | Specify:   |   | Specify: W                                     | hite   |
| 72 ho  | 'natur<br>dical B  | Completed         | 15. Decedent's Education (Specify only highest grade complete  | 16a. Dece<br>(Give   | edent's Usual Occup<br>e kind of work done<br>DO NOT use retired | oation<br>during most of work                    | ing   | 16b. Kind of Business                          | /Industry  |
| within   | than the Me  | ldmc              | Elementary/Secondary (0-12) Colleg   | e (1-4or 5+) stean   |  | a)   |   | Local 486                                      |  |
| e filed  | h and Mental Hygiene.<br>7 is marked other than<br>traumatic event, the Me   | Be C              | 17. Father's Name (First, Middle, Last)  |  |  | 18. Mother's Name                                | e (First, Middle, I                         | Maiden Surname)                                |  |
| <b>yaa</b><br>ould b   | Menta<br>larked  | To                | Wallace Wilson Stua  | ·  |  |  | Jane Cr                                     |  |  |
| ; INIAI YIAILI ZIZIOOOO<br>and 2 should be filed within 72 hours after death with the Maryland | Department of Health and Mental Hygiene.<br>Important: If item 27 is marked other than "natural", or items 23a or 28a-f show<br>any Injury or other traumatic event, the Medical Examiner must be notified at<br>once.             |                   | 19a. Informant's Name/Relationship (Type. Print) Gail Stuart   | wife P.C   | D. Box 174   |  | Spring                                      |  | NV 26763   |
| Pages 1  | Department of Health<br>Important: If item 27<br>any Injury or other tr<br>once.   |                   | 20a. Method of Disposition 1 ☐ Burial 2 ② Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)  | om State 20b. Place of Disp<br>cemetery, cre<br>Scarpelli Fu   | ematory or other plac  | ce)  | Date<br>3/16/2007                           | 20c. Location - City of Cresaptov              |  |
| permit. Pages  | Departr<br>Importa<br>any Inju<br>once,  |                   | 21. Signature of Funeral Service Licensee  | 1/1/1/ 2   | 22. Name and Addre<br>Scarpell<br>108 Viro                       | issof Facility<br>I Funeral Hor<br>Jinia Avenue: |   | d MD 21502                                     |  |
|  |  |                   | 23a Partz. Enter the disease, or complications the shock, or heart failure. List only one cause of   | at caused the death. Do not en   | iter the mode of dyir  | ng, such as cardiac                              | or respiratory arre                         | est,   | Approximate<br>Interval Between                  |
|  | nysician   |                   | Immediate Cause (Final disease or condition resulting in death)  | ACUTE M  | YOCARD   | IAL I  | NFAR  | CTION  | Onset and Death                                  |
|  | Medical<br>xaminer   |                   | Due Due  | to (or as a consequence of):   |  |  |   |  |  |
| P  | ¥.   | ner               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialted events   | to (or as a consequence of):   |  |  |   |  |  |
| Secure 6   | and<br>I-trans   | Examiner          | Cause (Disease or injury that initiated events c c   | to (or as a consequence of):   |  |  |   |  |  |
| ficate be execute  | ig physician and<br>as the burial-transit  |                   |  |  |  |  |   |  |  |
| ortificat  | ng phy<br>e as th  | Medi              | IF FEMALE:   |  |  |  | -   |  |  |
| death ce   | within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Medical | 23b. Was decedent pregnant in the past 12 months?  |  | □Ectopic pregnanc<br>□ Other <i>(specify)</i> _                  | ,<br>,   |   | 23d. Date of de<br>Month                       | Plivery<br>Day Year                              |
| that th  | ed by t<br>detach  |                   | 9 ☐ Unknown  Part II. Other significant conditions contributing t  | o death but not resulting in the u   | underlying cause giv   | en in Part I.                                    | 23e. Did tol                                | bacco use contribute t                         | to the cause of death?                           |
| v requires t   | n sign<br>uld be   | ed by             |  |  |  |  | -1 <u>5</u> 74                              | es 2. <b>X</b> No 3. □ F                       | Probably 4 ☐ Unknown                             |
| law re   | as bee<br>2 sho  | Completed         |  |  |  |  | 24a. Was a                                  | n 24b. Were a                                  | utopsy findings available completion of cause of |
| ian: The   | icate h<br>r, page   |                   |  |  |  |  | perform<br>1□ Yes                           | med?   death?                                  | _  |
| VIL  | s certif   | o Be              | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1   | ☑Inpatient 2☐ER/Outpatie   | ent 3 DOA Oth  | 26. Place of Deat                                |   | ence 6 □Other (Spe                             | naife)   |
| 5 g.   | fter thi   | <b>-</b>          | 27. Manner of Death 28a. D   | ate of injury 28b. Time (  |  |  |   | ow injury occurred                             | , cny)   |
| tending  | leath.<br>tor: Al<br>the fu  | catic             | 2 Accident investigation   | ace of injury - At home, farm, si  | M 1  | Yes 2 No   | 201   |  | 10 to M =====                                    |
| tal or Af  | rs after d<br>ral Direc<br>led in by   | Certification:    | 4 Homicide determined bi   | treet and Number or Rural Route Number,<br>rn, State)  |  |  |   |  |  |
| ne Hosp  | within 24 hours after death.  To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should  | Medical           | (Check only 2 Medical Examiner: On the   | the best of my knowledge, dea<br>e basis of examination and/or in<br>nanner stated.  | th occurred at the ti<br>nvestigation, in my                     | me, date and place,<br>opinion, death occur      | and due to the c<br>red at the time, d      | ause(s) and manner a<br>date and place, and du | s stated.<br>e to the cause(s)                   |
| To th  | withi<br>To tl   | Ň                 | 29b. Signature and title of certifier  | 2 /  | 29c. Licens  | se number  |   | 29d. Date signed (Mon                          | th, Day, Year)                                   |
|  |  |                   | 30. Name and address of person who completed of  | auso of death (Item 33a) (Type   | Brint)   | 33 11  | 1   | lugust   | 11, 200 1  |
|  | 4  |                   | 30. Name and address of person who completed to a completed of the complet | egistrar's Signature   | n+ Aver  | rue, Ci  | umberle                                     | and, MD,                                       | 21502  |
|  | Sta<br>Registr   |                   | AUG 1 6 2007   | Seus B. A.   | ach!   |  |   |  |  |
| DHMH   | I 17 Rev 1/2   | 001               |  | The same of the sa |  |  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month 3. Time of Death Day Year  $\mathbf{P}^{\mathsf{M}}$ NAOMI AUGUST 12, SULKIN 2007 5:20 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY 5. Social Security Number if Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In vrs. last birthday Date of Birth (Month, Day, Birthplace (State or Foreign Country) 1 □ M 2 🛛 F 87 1/16/1919 010-14-2906 MA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD MONTGOMERY SILVER SPRING Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12606 MEADOWOOD DRIVE 20904 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE Be Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ SOCIOLOGIST **GOVERNMENT** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROBERT LEVENSON GUSSIE COHEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JONATHAN SULKIN/son 23 CONVER DRIVE, SARATOGA SPRINGS, NY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐Cremation 3 ☐Removal from State 4 Donation 5 Dother (Specify) CUSTOM TAILORS CEMTRY 08/15/2007 ROXBURY, MA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 200 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEVERE SEPSIS disease or condition resulting in death) Due to (or as a consequence of): PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🛣 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ALZHEIMER'S DISEASE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2. 🛣 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2√☐ No 1 TInpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

it or Attending Physiclan: The law requires that the death certificate be executed attendenth. The refresh.

To Director: After this certificate has been signed by the attending physician and if in by the funeral director, page 2 should be detached for use as the burnal-transit Box 68760. P.O. Division or Vital Records. filled in by

Physician

**Funeral** 

Director

show

a or 28a-f sh

"natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must bonce.

**Physician** 

/Medical

Examiner

2

Examiner

Completed by Physician/Medical

Be

Certification: To

Medical

Baltimore, Maryland 21215-0036

the Maryland

with

/Medical

29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number DR63579

 $\overset{\text{29d. Date signed}}{\text{AUGUST}} \overset{\text{Month, Day }}{\text{2007}} \overset{\text{Part}}{\text{2007}}$ 

V

To the Hospital o within 24 hours aft To the Funeral Di

30. Name and address of Jerson who completed Suse of Lath (Item 23a) (Type, Print)

DR. MARIA J. TAYAG, 1500 FOREST GLEN RD, SILVER SPRING, MD 20910-1484

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of contifie



07 Pre

|  |                | State of Maryland / Department of He   |  | Reg. No.  | 07 2643                                   |
|--|----------------|--|--|---|---|
| ysicia   |                | Registrar  1. Decedent's Name (First, Middle,Last)   |  | Date of Death   | 3. Time of Death                          |
| xamir  | ner            | Prentis Short, Jr  |  | August 1, 2007  | 0735 hrs                                  |
|  |                | 6215 Erland Way  | ity, Town, or Location of Death<br>anham                                   | 4c. County of Dea<br>Prince Geor                                    | ge's                                      |
| neral<br>ector   |                | 249-41-1827 1X M 2 F 41 Yrs.   | lonths Days Hours Min.   | B. Date of Birth(MM/DD/YYYY) 9. In Form August 6.1965               | eign South Car                            |
| any  | ŀ              | Usual Residence of Decedent  10a, State 10b. County 10c. City, Town or Location  |  | <del> </del>  | 10d. Inside City Limits                   |
| how a  | _              | Maryland Prince Geosge's   | Lanham   |   | 1 Yes 2 X No                              |
| 23a or 28a-f show<br>notified at once.   | Director       | 10e. Street and Number   | f. Zip Code  | 10g. Citizen of What Co   | ountry?                                   |
| a or 2<br>tiffed   | ă              | 6215 Erland Way  | 20723  | U.S.A.  |   |
| ns 23<br>be no   | uneral         | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was De  | cedent of Hispanic Origin? (Speci<br>specify Cuban, Mexican, Puerto Ric    | .,  | erican Indian, Black,                     |
| or ite   | Fu             | 1 X Never Married 2 Married 1 Yes 2X No  |  |   | **  |
| ral",  | by F           | or Dates:  | s 2X No specify:   | Specify: B1 k done 16b. Kind of Busines                             |   |
| Exam   | eted           | during most of   | of working life, DO NOT use retired  |   | is industry                               |
| han dical  | ple            | Tan  | nitor  | School  | System                                    |
| marked other than "natural",<br>c event, the Medical Examiner  | Comple         | 12 Jail 17. Father's Name (First, Middle, Last)  |  | irst, Middle, Maiden Surname)                                       | Dy B CCIII                                |
| ked o  | Be C           | Prontic Chart Cr   | Marv_M   | alachi  |   |
| and mental riggicule.  7 is marked other thatic event, the Med   | ToE            | 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Ad  | dress (Street and Number or Rur  | al Route Number, City or Town, St                                   | ate, Zip Code) 29520                      |
| 27 is  |                | Mrs Mary Short/Mather 106 Th   | nird Street.   | Cheraw South (  | Carolina                                  |
| r tra  |                | 20a. Method of Disposition 20b. Place of Disposition   | dace)  | Date 20c. Location - City   |   |
| refit  |                | 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  | nurch Cem. 8-8   | Wallace   | South Caro                                |
| Department of Health and M<br>Important: If item 27 is ms<br>injury or other tranmatic e   |                | 21. Signature of Funeral Service Licensee 22. Name   | e and Address of Facility Marz   | ullo Funeral  | Chapel, P. A                              |
| <b>2</b> . <b>2</b> .5   |                | hardest Phaneller 16009  | Harford Road   | l Baltimore.Ma  | aryland2121                               |
| ician  |                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the m failure. List only one cause on each line.  | node of dying, such as cardiac or re                                       | espiratory arrest, shock, or heart                                  | Approximate Interval<br>Between Onset and |
| dical<br>niner   |                | Immediate Cause (Final disease a Morbid obesity with complice  | tions  |   | Death                                     |
|  |                | or condition resulting in death)  Due to (or as a consequence of):   |  |   |   |
|  | <u>-</u>       | Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of):  |  |   |   |
|  | mi             | Co. Co. Co. Co. Co. Co. Co. Co. Co. Co.  |  |   | -121                                      |
| ısıt   | Examine        | events resulting in death) Last Due to (or as a consequence of):   |  |   |   |
| n and<br>- tra   | ical           | C. AMENDED   |  |   |   |
| /sicia<br>burial   |                | X UNPENDED AMENDED #Z3a,27, perME, g871, 9/4/07  | TT   | 23d. Date of deli   | verv                                      |
| attending physician and<br>for use as the burial - transit   | Physician/Med  | IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal 0  | death 3 Ectopic pregnance  |   | Day Year                                  |
| tendi  | ici<br>is      |  | (Specify)  |   |   |
| has been signed by the att<br>2 should be detached for   | hys            | 1 Yes 2 No 9 Unknown g Unknown   | aluing serves sives in Dort I  | 23e. Did tobacco use contribute                                     | e to the cause of death?                  |
| within 24 hours after death.  Fo the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bunition | by P           | Part II. Other significant conditions contributing to death but not resulting in the under   | enying cause given in Fart i.  | 1 Yes 2 No 3  |   |
| n sign<br>Id be  | ed             |  |  |   | e autopsy findings available              |
| shou   | Completed      |  |  | autopsy prior performed? deat                                       | to completion of cause of                 |
| ate h  | E              |  |  |   | Yes 2 No                                  |
| certificate<br>ector, page   | 0              | 25. Was case referred to medical   | 26.Place of Death (Check or  |   |   |
| this c   | 8<br>2         | examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3   |  | Home 5 Residence 6 ✔ C  | Other: Scene                              |
| After  | Ë              | 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury   | ' I _ ' _ I  | 28d. Describe how injury occurred                                   |   |
| ours after death.  eral Director: After this certif: filled in by the funeral director,  | atio           | 1 X Natural 5 Pending 2 Accident Investigation   | 1 Yes 2 No   | 201.1   | Pinnel Davida Alimah an Olin.             |
| after death<br>Director:<br>I in by the  | Ęį             | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, f   | actory, office building, etc.  | 28f. Location (Street and Number of Town, State)                    | r Kurai Koute Number, City                |
| 24 hours after death. Funeral Director: stely filled in by the   | Certification: | 4 Homicide determined (Specify)  |  |   | -1-1-1                                    |
| within 24 hours:  To the Funeral completely filled   | cal            | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred one) Wedical Examiner: On the basis of examination and/or investigation  | i at the time, date and place, and d<br>, in my opinion, death occurred at | lue to the cause(s) and manner as the time, date and place, and due | stated.<br>to the cause(s)                |
| within<br>To the<br>comple   | Medical        | and manner stated.   | 29c. License number  |   | (Month, Day, Year)                        |
|  | Z              | 29b. Signature and title of certifier  | O.C.M.E.   | August 2, 200   |   |
|  |                | Thede M. 16, of Things   | J. J. IVI.E.   | ,   |   |
|  | 1              | The state of the s |  |   |   |
|  |                | 30. Name and address of person who completed cause of death (Item 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 1  | 11 Penn Street, Baltimore  | MD 21201  |   |

07-06109 Ra

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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|-------|--------|----|
| · - ! | <br>26 | 10 |

| indy Stevens<br>1   | State of Maryland / Dep  | eartment of Health and Menta<br>ertificate of Death  | ai nygiene<br>Reg. N                            | <u>~ U . , ~ A B . ∪</u><br>Io.  |
|---|--|--|---|--|
| Physician/  | egistrar<br>. Decedent's Name (First, Middle,Last)   | 2. Date of Death<br>Month Da   | 3. Time of Death Year 0709 hrs                  |  |
| ****al Examiner   | Randy Eugene STEVENS la. Facility Name (if not institution, give street and number)  | 4b. City, Town, or Location of   | August 9, 200                                   | 4c. County of Death  |
|   | 251 E. Antietam Street   | Hagerstown   |   | Washington   |
| Funeral<br>Director   | 5. Social Security Number 6. Sex 7. Age (In yrs 212-80-6802 1 M 2 F 45   | last birthday) If Under 1 Year If Under Months Days Hours  | **24Hrs. 8. Date of Birth(M<br>Min. 2/2/196     | M/DD/YYYY) 9. Birthplace (State or Foreign Country)Maryland                      |
|   | Usual Residence of Decedent  | ty, Town or Location   |   | 10d. Inside City Limits  |
| ow any  | Maryland Washington  | Hagerstown   |   | 1 Yes 2 X No   |
| he Maryland i or 28a-f she iffed at once  | 10e. Street and Number   | 10f. Zip Code  | 10g.  | Citizen of What Country?   |
| the Ma a or 28 tiffied a  | 11965 Azalea Drive   | 21740  | <b>■</b> 10 ] _                                 | USA  14. Race - American Indian, Black,  |
| r death with<br>or items 23<br>must be no   | 11. Marital Status 1 Never Married 2 X Married Armed Forces?   | U.S. 13. Was Decedent of Hispanic Orig<br>If Yes, specify Cuban, Mexican,  | in? ( Specify Yes or No-<br>Puerto Rican, etc.) | White, etc.  |
| er deat<br>, or ite<br>r must   | 3 Widowed 4 Divorced or Dates:   |  | 1.54  | Specify: white   |
| urs afte  | 15. Decedent's Education (Specify only highest grade completed   | 16a. Decedent's Usual Occupation (Give during most of working life. DO NOT   |   | 6b. Kind of Business/Industry  |
| within 72 nour giene. her than "natu ompleted   | Elementary/Secondary (0-12) College (1-4 or 5+)  | Senior Computer Te   |   | research marketing   |
| -003<br>I within<br>giene.<br>Ther th   | 12 0   | 18.Mother  | 's Name (First, Middle, Mai                     |  |
| 21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner TO Be Completed by   | Chester Stevens  | He1  19b. Mailing Address (Street and Num  | en Shreve                                       | or City or Town State Zin Code)  |
| ore, MD 21215-0036 ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f she ther traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director  | 19a. Informant's Name/Relationship (Type, Print)  Donna Stevens - wife   |  |   | m, Maryland 21740  |
| M 2 aum   | 20a. Method of Disposition 20  | b). Place of Disposition (Name of cemetery, crematory or other place)  | Date 2  | 20c. Location - City or Town, State  |
| nore<br>ages 1<br>nr of H<br>nt: If i   | 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  | Rose Hill Cemetery   | 8/13/07   | Hagerstown, Maryland   |
| Baltimore, Deprinit. Pages I ai Department of the Important: If the injury or other tr  | 21. Signature of Funeral Service Licensee  | 22. Name and Address of Facilit  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the de  | eath. Do not enter the mode of dying, such as of   | Lvd., Hagers cardiac or respiratory arres       | town, Mary 1 and 21740 t, shock, or heart Approximate Interval Between Onset and |
| Physician<br>Medical  | failure. List only one cause on each line.   | theosclerotic cardiovascul   |   | Death  |
| aminer  | Immediate Cause (Final disease or condition resulting in death)  a Hypertensive 2  Due to (or as a consequence)  | ce of):  |   |  |
|   | Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequen   | ce of):  |   |  |
| ed gramine  | cause. Enter Underlying Cause (Disease or injury that initiated  | ce of):  |   |  |
| Ex assist and a second  | events resulting in death) Last Due to (or as a consequent   |  |   |  |
| 50, Ke be executed to be executed sysician and the transit herizate transit   | X UNPENDED AMENDED 47. perM  | E,g871, 9/7/ <u>07 TT</u>  |   | 23d. Date of delivery  |
| 760<br>ficate the physic street but the physical street but 1/Me  | IF FEMALE: 23c. If yes, outcome of 23b. Was decedent pregnant in the   | pregnancy  | oic pregnancy                                   | Month Day Year   |
| ox 6876 ath certificate attending phy or use as the sician/M  | past 12 months?  4 Pregnant at time  1 Yes 2 No 9 Unknown 9 Unknown  |  |   |  |
| Records, P.O. Box 6876. The law requires that the death certificate cate has been signed by the attending phy page 2 should be detached for use as the Completed by Physician/M.  |  | not resulting in the underlying cause given in F   |   | pacco use contribute to the cause of death?                                      |
| P.O ss that 1 gened b be deta   |  |  | 1Yes  | 2 No 3 Probably 4 Unknown  |
| Records, I The law requires freate has been sig page 2 should be Completed  |  |  | 24a. Was a autops                               | prior to completion of cause of  |
| eco<br>he law<br>ate has<br>age 2 s   |  |  | 1 ✓ Yes 2                                       |  |
| clan: T certific ector, p   | 25. Was case referred to medical   | 26.Place of Deat 2 PER/Outpatient 3 DOA Other  | th (Check only one)  Nursing Home 5             | Residence 6 Other:   |
| F Vite Physic Physic ral dire   | 1 V Yes 2 No 28a, Date of Injury   | 28b. Time of Injury 28c. Injury at Wo  |   | ow injury occurred   |
| on on ording of the function?   | 1 X Natural 5 Pending (Month, Day, Year)   | 1 Yes 2  |   |  |
| Division of Vital Records, P.O. Box 6876. Tall or Attending Physician: The law requires that the death certificate ins after death.  Find Diversor: After this certificate has been signed by the attending phylical birector, page 2 should be detached for use as the Lordinary or the functal director, page 2 should be detached for use as the Dertification: To Be Completed by Physician/IM. | 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury   | At home, farm, street, factory, office building,   | etc. 28f. Location (S<br>or Town, St            | Street and Number or Rural Route Number, City tate)                              |
| ig hou by   |  | owledge, death occurred at the time, date and  | place, and due to the caus                      | e(s) and manner as stated. and place, and due to the cause(s)                    |
| To the He within 24 To the Fu completel   | one) 2 Medical Examiner: On the basis of examina and manner stated.  | 29c. License numb  | oer   | 29d. Date signed (Month, Day, Year)  |
|   | 29b. Signature and title of certifier  | O.C.M.E.   | DOME  | August 10, 2007  |
|   | 30. Name and address of person who completed cause of death  | (Item 23a)   |   |  |
|   | Theodore M. King, Jr., MD. Assistant Med   | cal Examiner 111 Penn Street, E  | Baltimore, MD 21201                             | 1  |
| Stat  | BILO 1 (5 7/1/1/ LPF/F of the control of the contro | ignature de la constant de la consta |   |  |
| Registra<br>DHMH 17 Rev 1/200   | 1100   | ORIGINAL   |   |  |

3. Time of Death

|                            | Physici   | an                | C - c - c   |   | St)  | Q1-                        | 2112 .  |  |                                |                                | Month                      | Day                        |   |                        | inne or Death                           |   |                   |          |   |
|----------------------------|---|-------------------|---|---|--|----------------------------|---|--|--------------------------------|--------------------------------|----------------------------|----------------------------|---|------------------------|---|---|-------------------|----------|---|
|                            | /Medio  |                   | Georg   |   | etreet and number)   | Sn                         | illing  | 4h City Town   | or Location                    |                                | August                     | 2007<br>County of Deat     |   |                        |   |   |                   |          |   |
| À                          | Examin  | er                | 21895 Pegg  |   |  |                            | 4b. City, Town, or Location of Death Lexington Park |  |                                |                                |                            | St. Mar                    |   |                        |   |   |                   |          |   |
|                            | Francis   | -                 | 5. Social Security Num  |   |  | e (In yrs. i               | last birthday)                                      | If Under 1 Year  |                                |                                | B. Date of Bi              |                            |   |                        | State or Foreign                        |   |                   |          |   |
| п                          | Funeral<br>Director   |                   | 579-50-375  | 4   | M 2□F  | 68                         | Yrs.  | Months Day   | s Hours                        | Min.                           | (Month, D<br>03/01         | ay, Year)<br><b>/193</b> 9 | Unk                                       | untry)<br>nowr         |   |   |                   |          |   |
|                            | D   |                   | Usual Residence of De   |   |  |                            |   |  |                                |                                | 007.02                     | , 2,00                     |   |                        |   |   |                   |          |   |
|                            | ırylan<br>I <b>how</b><br>Lat   | _                 | 10a. State  | 10b. County   |  | 10c. City                  | y, Town or Loc                                      | ation  |                                |                                |                            |                            | 10d. Inside C                             |                        |   |   |                   |          |   |
|                            | e Ma<br>Ba-f s  | cto               |   | St. Mary  | y's  | Lex                        | xingtor   | 1  |                                |                                |                            |                            |   |                        | □Yes 2√X No                             |   |                   |          |   |
|                            | ith th  | Director          | 10e. Street and Numb  | er  |  |                            |   | 10f. Zip Code  |                                |                                |                            | 10g. Cit                   | 0g. Citizen of What Country?              |                        |   |   |                   |          |   |
|                            | ath w   | ral               | 21895 Pegg  | Road,   |  |                            | 0 100   | 20653  |                                | 1:0/0                          |                            |                            | nited States  14. Race - American Indian, |                        |   |   |                   |          |   |
|                            | er de<br>items  | Funeral           | 11. Marital Status  | - O - 14  | 12. Was Decedent<br>Armed Forces?  |                            | .S.   13. V   | Vas Decedent of<br>Yes, specify Cu                     | Hispanic O<br>iban, Mexica     | rigin? (Speci<br>an, Puerto Ri | ican, etc.)                | 0-                         | Black, Whit                               |                        | nari,                                   |   |                   |          |   |
| 21215-0036                 | 72 hours after death with the Maryland<br>'natural', or items 23a or 28a-f show<br>dical Examiner must be notified at   | by                | 1 XNever Married<br>3 ☐ Widowed 4   |   | 1  Yes 2  If Yes, Give<br>Year or Dates:                                   | INO .                      | 1   | □Yes 2XIN  | o Specify                      | <i>/</i> :                     |                            |                            | Specify: Wh                               | ite                    |   |   |                   |          |   |
| 5-0                        | ges 1 and 2 should be filed within 72 hours<br>t of Health and Mental Hyglene.<br>If item 27 is marked other than "natural",<br>or other traumatic event, the Medical Exa   | Be Completed      | 19<br>(Specify  | <ol> <li>Decedent's Edy<br/>only highest gra</li> </ol> | ducation<br>ade completed)   |                            | 16a. Deced<br>(Give )                               | ent's Usual Occ<br>kind of work don<br>OO NOT use reti | upation<br>e <i>during m</i> o | st of working                  | 7                          | 16b. K                     | ind of Business/                          | Industry               |   |   |                   |          |   |
| 12                         | filed within<br>Hygiene.<br>ther than "   | du                | Elementary/Second   | dary (0-12)   | College (1-4or 5   | 5+)                        |   | ouse Wo  |                                |                                |                            | II C                       | Govern                                    | mani                   | <b>+</b>                                |   |                   |          |   |
| 7                          | Hygid<br>Hygid<br>ther  | ပိ                | 17. Father's Name (FI   | irst. Middle, Last                                      |  |                            | waren   | ouse wo  |                                | ner's Name (                   | First, Middle              |                            |   | щеп                    |   |   |                   |          |   |
| Maryland                   | d be sintal   | Be                | Harry Andr  |   |  |                            |   |  | 77 f ra co                     | inia 1                         | 0                          | II a mana                  |   |                        |   |   |                   |          |   |
| $\bar{\Sigma}$             | should<br>and Men<br>s marke<br>umatic  | Ĕ                 | ř   | 2   | ř  | -                          | 19a. Informant's Nam                                |  |                                |                                | 19b. Mailin                | g Address (Stre            | 1940                                      |                        |   | - | or Town, State, 2 | Zip Code | ) |
| Z                          | nd 2 statth and 2 state and 2 |                   | Rev. John   | Δ Rall  | /Friend  |                            | P O   | Box 207  | St                             | Mary                           | e Cit                      | or MT                      | 20686                                     |                        |   |   |                   |          |   |
| ē,                         | s 1 a<br>f Hea<br>item<br>othe  |                   | 20a. Method of Dispos   | sition  |  | 20b. P                     | Place of Dispos                                     | sition (Name of<br>natory or other p                   | lace)                          | Da                             |                            | 20c. Lo                    | ocation - City or                         | Town, S                | tate                                    |   |                   |          |   |
| e<br>E                     | Page<br>ent o<br>nt: If<br>ry or  |                   | 1 ☐ Burial 2 🔀 0<br>4 ☐ Donation 5  | Cremation 3 ☐<br>☐ Other (Specif                        | Removal from State   | 1                          |   |  | 1                              | ng /ng /                       | 2007                       | Cha                        | rlotte                                    | Hall                   | . MD                                    |   |                   |          |   |
| Baltimore,                 | permit. Pages of Department of Important: If ite any injury or of once.   |                   | 21. Signature of Fune   |   |  |                            | 22  | . Name and Add   | ress of Faci                   | lity Bri                       | nsfiel                     | ld Fu                      | neral H                                   | ome,                   | P.A.                                    |   |                   |          |   |
| m                          | a T P P   |                   | Kyle S.   | . Simons  | M01206   |                            | 2   | 2955 Но  | Llywoo                         | d Rd.                          | Leona                      | ardto                      | wn, MD                                    | 2065                   | 0                                       |   |                   |          |   |
|                            | Physician   |                   | 23a. Part1. Enter the<br>shock, or heart t<br>Immediate Cause (Fir<br>disease or condition<br>resulting in death) | failure. List only                                      | plications that caused one cause on each line.  a. Cardinate Due to (or as | ne.                        |   |  | _                              | s cardiac or                   | respiratory                | arrest,                    |   | Appr<br>Inter<br>Onse  | roximate<br>val Between<br>et and Death |   |                   |          |   |
| 7                          | /Medical<br>Examiner  |                   | resulting in death)   |   | Due to (or as  | a consequ                  | uence of  | 01.6   |                                |                                |                            |                            |   |                        |   |   |                   |          |   |
| 100                        | _xammo  | <u>.</u>          | Sequentially list condi   | litions,  | b 0 - 200  | 2000                       | S (   | nellin   | 3-                             |                                |                            | _                          |   |                        |   |   |                   |          |   |
|                            | ted<br>Isit   | Examiner          | Sequentially list condi-<br>many, reading to infini-<br>cause. Enter Underly<br>Cause (Disease or inj             | ying dury   | 1 8 . 1  | - 1-                       | - 0-  |  |                                |                                |                            |                            |   |                        |   |   |                   |          |   |
|                            | xecur<br>al-trar  | xan               | that initiated events<br>resulting in death) Las  |   | c. Due to for As   | a consequ                  | uence of):  |  |                                |                                |                            |                            |   |                        |   |   |                   |          |   |
| 760                        | icate be executed<br>physician and<br>s the burial-transit  |                   |   |   |  |                            |   |  |                                |                                |                            |                            |   |                        |   |   |                   |          |   |
| 89                         | ificate<br>g phy<br>as the  | edic              |   |   | - 00   |                            |   |  |                                | ·                              |                            |                            |   |                        |   |   |                   |          |   |
| .O. Box 68760,             | res that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit  | Physician/Medical | IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ N 9 ☐ Unknown   | nonths?   | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant a<br>9 □ Unknown    | 2 Feta                     | ıl death 3 🗌  | Ectopic pregnar<br>Other <i>(sp</i> ec <i>ify)</i>     |                                |                                |                            |                            | 23d. Date of de<br>Month                  | livery<br>Day          | Year                                    |   |                   |          |   |
| σ.                         | that<br>ned b   |                   | Part II. Other significa  | ant conditions  | contributing to death b  | ut not resu                | ulting in the un                                    | derlying cause   | given in Part                  | 1.                             | 23e. Did                   | tobacco                    | use contribute to                         | the cau                | use of death?                           |   |                   |          |   |
| rds                        | quires<br>n sign<br>uld be  | q p               | ps-70   | husis   | 5.   |                            |   |  |                                |                                | 1 🗆                        | Yes 2                      | No 3□P                                    | robably                | 4 □Unknown                              |   |                   |          |   |
| Seco                       | Attending Physician: The law requires that the roleath. ector: After this certificate has been signed by the tuneral director, page 2 should be detache   | Completed by      |   |   |  |                            |   |  |                                |                                | 24a. Wa<br>aut             | s an<br>opsy<br>formed?    | 24b. Were au prior to death?              | utopsy fii<br>completi | ndings available<br>on of cause of      |   |                   |          |   |
| a                          | ician: The<br>certificate ha<br>ector, page   | ပိ                | 05 14/  | d to modical  |  |                            |   |  |                                |                                | 1∐ Yes                     | 2 <b>X</b> No              | 1 ☐ Yes                                   | 2 🗆 1                  | No                                      |   |                   |          |   |
| Ę                          | sician:<br>certific<br>irector,   | Be c              | 25. Was case referred examiner?  1 ☐ Yes 2 ☑ No   |   | Hospital: 1 ☐ Inpatio  | ant 2                      | ER/Outpatien  | 3000   | thor:                          | ce of Death                    |                            |                            | 0 Dother (0-                              | -14-1                  |   |   |                   |          |   |
| ō                          | Physer this eral di   | - T               | 27. Manner of Death   |   | 28a. Date of Inju  |                            | 28b. Time of  | 28c. In  |                                |                                |                            |                            | 6 □Other (Spe                             | city)                  |   |   |                   |          |   |
| lon                        | nding F<br>th.<br>: After<br>e funera   | ţi                | 1 X Natural<br>2  Accident  | 5 ☐ Pending investigation                               |  | ıy Year)                   | Injury  |  | fork?<br>□Yes 2□               | □No                            |                            |                            |   |                        |   |   |                   |          |   |
| Division or Vital Records, | after dea   | Certification:    |   | 6 Could not be determined                               |  | ury - At ho<br>tc. (Specif | ome, farm, stre                                     | eet, factory, offic                                    | е                              | 28                             | Bf. Location<br>City or To | (Street ar<br>own, State   | nd Number or R<br>e)                      | ural Rou               | te Number,                              |   |                   |          |   |
|                            | To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu  | edical C          |   |   | nysician: To the best<br>niner: On the basis o<br>and manner st            | of examina                 |   |  |                                |                                |                            |                            |   |                        |   |   |                   |          |   |
|                            | To th<br>Withir<br>To th<br>comp  | Me                | 29b. Signature and tit  | tle of certifier  | A  |                            |   | 29c. Lice  | nse number                     |                                |                            | 29d. Da                    | ate signed (Moni                          | th, Day,               | Year)                                   |   |                   |          |   |
|                            |   |                   | ) lact  | ta D  | · Unas   | en                         |   | D32  | 2651                           |                                |                            | 8/                         | 8/2007                                    |                        |   |   |                   |          |   |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Rita Jhaveri, M.D.
31. Date filed (Month, Day, Year)
AUG 1 0 2007

State Registrar

**ORIGINAL** 

22335 Exploration Drive #2, Lexington Park, MD 20653

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 11:00A M August 8, 2007 Justino Sierra /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Civista Medical Center La Plata Charles If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 11 M 2 □ F Yrs. Nov. 10,1917 Director 89 Puerto Rico 580-44-1480 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2K No Director Charlotte Hall MD St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20622 U. S. A. 29449 Charlotte Hall Road Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1XX Yes 2 □ No If Yes, Give Year or Dates: 143-146 1 Never Married 2 Married 1 XYes 2 No Specify: Hispanic þ 3 ☐ Widowed 4 € Divorced Puerto Rican Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner and Operator of Shop Art Framing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Belen Alejandro Blass Sierra ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1900-214 Thames Street Baltimore, Maryland 21231 Rolando Sierra / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition August 10, 1 ☐ Burial 2 【© Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 2007 Charlotte Hall, MD Brinsfield-Echols Cr. 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. 1000 20622 M00641 30195 Three Notch Road, Charlotte Hall, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) avers pulmonon /Medical Due to (or as a consequence of): Examiner Figure 1 in the second of the Due to (or as a consequence of) Examine The law requires that the death certificate be executed bunal-tran Due to (or as a consequence of): attending physician for use as the buna Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown been signed t should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No Unknown 1 Yes 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 1 ☐ Yes 1 Inpatient 3□ DOA Certification: To within 24 hours after death.

To the Funeral Director; After thi completely filled in by the funeral 27. Manuar of Death 28a, Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural

Accident Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

29b. Signature and title of certific

31. Date filed (Month,

AKINPELU

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Crista Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

Center, Laplate, mis

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|            |   |                         | For State Of IVIA Registrar   |   | rtificate of Death   | , ,                                       | . No. 2017 26434   |
|------------|---|-------------------------|---|---|--|---|--|
| ide        | Physici   | an                      | 1. Decedent's Name (First, Middle, Last)  |   |  | 2. Date of Death<br>Month                 | Day Year 9:45 P M  |
|            | /Medic  | al                      | Martin Leonard Sweeney, Ja  4a. Facility Name (If not institution, give street and number)  | r •   | 4b. City, Town, or Location of Death   | July 31                                   | , 2007 9:45 P M 4c. County of Death                                  |
| A.         | Examin  | er                      | College View Nursing Home   |   | Frederick  | Frederick                                 |  |
|            | Funeral<br>Director   |                         | 287 <b>–</b> 16 <b>–</b> 9087   | e (In yrs. last birthday)<br>85 Yrs.            | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.   | 8. Date of Birth (Month, Day, Y) July 25, | 9. Birthplace (State or Foreign<br>Country)<br>1922 Ohio             |
|            | land<br>pw<br>t   |                         | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, Town or Lo                           | cation   | 10d. Inside City Limits                   |  |
|            | Mary<br>a-f she<br>ified a  | tor                     | MD Frederick  | Frederick                                       |  |   | 1X Yes 2 No  |
|            | or 28   | Direc                   | 10e. Street and Number  |   | 10f. Zip Code  |   | . Citizen of What Country?   |
|            | eath w  | <b>Funeral Director</b> | 700 Toll House Avenue  11. Marital Status 12. Was Decedent F  | Ever in U.S. 13.                                | 21701 Was Decedent of Hispanic Origin? (S  | US<br>pecify Yes or No-                   | A. 14. Race - American Indian,                                       |
| 36         | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by Fun                  | Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  Armed Forces?  1 Yes 2 N  1 Yes, Give  Year or Dates:             | 10  | Was Decedent of Hispanic Origin? (S<br>if Yes, specify Cuban, Mexican, Puerl<br>1 □ Yes 2【 No Specify: | to Rićan, etc.)                           | Black, White, etc.  Specify: White                                   |
| 21215-0036 | 72 hou<br>natura<br>dical E   | Completed by            | 15. Decedent's Education<br>(Specify only highest grade completed)  | 16a. Deced                                      | dent's Usual Occupation<br>kind of work done during most of wo<br>DO NOT use retired)                  | rking 16                                  | b. Kind of Business/Industry   |
| 121        | within and the Med  | mple                    | Elementary/Secondary (0-12)  College (1-4or 5   | +) Attor  |  |   | Law  |
|            | Hygie<br>other<br>ent, th   | Be Co                   | 17. Father's Name (First, Middle, Last)   | ALLOI   |  | me (First, Middle, Ma                     |  |
| /lan       | Menta<br>Menta<br>arked<br>artic ev   | ToB                     | Martin Leonard Sweeney  |   | Marie Ca   | arlin                                     |  |
| Maryland   | d 2 should be filed within th and Mental Hygiene. 7 is marked other than "traumatic event, the Mer  |                         | 19a. Informant's Name/Relationship (Type. Print)  Kathleen Savitz/daughter  |   | ng Address <i>(Street and Number or Ri</i><br>. <b>Split Creek Ct.</b>                                 |   |  |
|            | s 1 and 2<br>f Health<br>Item 27 i  |                         | 20a. Method of Disposition  | 20b. Place of Dispo                             | sition (Name of matory or other place)   | Date 20                                   | Oc. Location - City or Town, State                                   |
| imo        | Page:<br>nent o<br>ant: If<br>ury or  |                         | 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)   |   | ce Crematory 08/0  | 02/07 Be                                  | eltsville, MD  |
| Baltimore, | permit. Pages 1 and<br>Department of Health<br>Important: If Item 27<br>any injury or other tr  |                         | 21. Signature of Funeral Service Licensee   | MO1251 Be                                       | 2. Name and Address of Facility<br>oing Home Cremation   | te. P.A. (                                | Clarksville, MD 21029  |
|            |   |                         | 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir             | the death. Do not ent                           | er the mode of dying, such as cardia   | c or respiratory arres                    | t, Approximate Interval Between Onset and Death                      |
|            | Physician /Medical  |                         | resulting in death)   | a consequence of):                              | enttive puem   | ONARY                                     | DISEASE 20 YRS   |
|            | Examiner  |                         |   | a consequence or,                               |  |   |  |
|            | p <sub>i</sub> tis  | iner                    | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | a consequence of):                              |  |   |  |
|            | tificate be executed<br>g physician and<br>as the burial-transit  | Examiner                | resulting in death) Last  C   | a consequence of):                              |  |   |  |
| 68760,     | te be e<br>/sician<br>e burit   | edical E                | d   |   |  |   |  |
|            | ertificating physe as th  |                         | IF FEMALE:  |   |  |   |  |
| D. Box     | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | Physician/M             | 23b Was decadent prograph 23c. If yes, outcome  | 2 Fetal death 3                                 | □Ectopic pregnancy<br>□ Other (specify)  |   | 23d. Date of delivery  Month Day Year                                |
| P.O        | that the dened by the statement   |                         | Part II. Other significant conditions contributing to death be  | ut not resulting in the u                       | nderlying cause given in Part I.   | 23e. Did toba                             | acco use contribute to the cause of death?                           |
| rds        | quires tha<br>in signed I<br>uld be det   | d be                    | DEMENTA, TA, A  | SORMAL PR                                       | eassner Hypro-   | - 1 □ Yes                                 | 2 □ No 3 □ Probably 4 □ Unknown                                      |
| Records,   | law requir<br>as been si<br>2 should l  | Completed by            | CAPHACUS, MVP   |   |  | 24a. Was an<br>autopsy                    | 24b. Were autopsy findings available prior to completion of cause of |
| al<br>R    | sician: The law certificate has birector, page 2 s  |                         |   |   |  | performe<br>1∐ Yes 2                      | ed? death?<br>XNo 1 □ Yes 2 □ No                                     |
| Vital      | ing Physician: The It. After this certificate ha funeral director, page   | o Be                    | 25. Was case referred to medical examiner?  1  Yes 2  No Hospital: 1 Inpatie  | ent 2 ☐ ER/Outpatier                            |  | ath <i>(Check only one)</i>               | ice 6 Other (Specify)  |
| OC         | ding Phys<br>n.<br>After this<br>funeral di   | n: To                   | 27. Manner of Death 28a. Date of Inju   | ry 28b. Time o                                  |  | 28d. Describe how                         |  |
| sior       |   | catio                   | 2 Accident investigation  |   | M 1 ☐ Yes 2 ☐ No   | 00( ) (0)                                 |  |
| Division   | I or Attend<br>after death.<br>Director: /  | Certification:          | 4 Homicide determined 28e. Place of injusting, et   | ury - At home, farm, sti<br>c. <i>(Specify)</i> | геет, тастогу, опісе   | City or Town,                             | eet and Number or Rural Route Number,<br>State)                      |
|            | _ (0  | 0                       | 29a. Certifier 1 X Certifying Physician: To the best  | of my knowledge, deat                           | h occurred at the time, date and place   | e, and due to the car                     | use(s) and manner as stated.   |
|            | Hospital<br>24 hours a<br>Funeral I<br>etely filled   |                         | (Check only one) 2 Medical Examiner: On the basis one and manner sta  | f examination and/or in                         | nvestigation, in my opinion, death occ   | uned at the time, da                      | te and place, and due to the cause(s)                                |
|            | To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the  | Medical                 | (Check only 2 Medical Examiner: On the basis o  | f examination and/or in                         | 29c. License number  |   | d. Date signed (Month, Day, Year)                                    |
|            | To the Hospital of within 24 hours aff To the Funeral D completely filled in  |                         | (Check only one) 2 Medical Examiner: On the basis o and manner sta  | f examination and/or in                         |  | 296                                       |  |
| 2+         | To the Hospital within 24 hours a To the Funeral Completely filled  |                         | (Check only one) 2 Medical Examiner: On the basis o and manner sta  | f examination and/or in ated.                   | 29c. License number  D Z-1 9 3 %   | 290<br>Au                                 | d. Date signed (Month, Day, Year)                                    |

State Registrar

31. Date filed (Month, Day, Year)
AUG 0 3 2007

32. Refistrar's Signature

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending Physician; the Funeral

Maryland 21215-0036

Baltimore,

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

CP

12

MO

555

32 Registrar's Signature

and manner stated.

30. Name and address of person completed cause of death (Item 23a) (Type, Print)

mo

unconne

AUG 0 3 2007

EX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 0250 Fay McClelland Sellers 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** aional medical Cent NICOMICO ninsula Le 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 M 2 □ F Director 194-09-1682 2-24-1915 Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits r 28a-f show notified at 1X Yes 2 No Director MD Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 28269 Log Cabin Road 21801 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Salesman permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If Item 27 is marked other th any Injury or other traumatic event, the once. 12 Muellers Macaroni 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William J. Sellers Irene McIntyre 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28269 Log Cabin Road, Salisbury, MD 21801 Kelly Ritchey - daughter 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8-4-2007 Presbyterian Cemetery Hollidaysburg, PA 21. Ignature V Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PREUMONIL **Physician** spiration ecurrent /Medical Due to (or as a consequence of): **Examiner** d vanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical examiner? funeral director 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2No Hospital: 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 No 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

P.O. Box 68760, Division or Vital Records, e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifice To the I within 2. To the I

Certification: To filled in by the Medical

4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29a. Certifier (Check only one) 6 Could not be determined

29b. Signature and title of certifier

29c, License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 08-01-2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

100 E. Carroll St. Splisbury, Md. 21801 Varadarajan Anupama 31. Date filed (Month

egistrar's Signature

and manner stated.

State

| Physician /Medical Examiner  Nile A. Stalnaker  4a. Facility Name (If not institution, give street and number)  The Pines Genesis HealthCare Easton  The Pines Genesis HealthCare Faston  S. Social Security Number  235-16-1974  Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  MD  TALBOT  TALBOT  10c. City, Town or Location  10d. Zip Code  809 N. WASHINGTON ST.  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  1 S. Decedent's Education (Specify only highest grade completed)  1 S. Decedent's Education (Give kind of work done during most of working life. Do Not use retired)  TRUCK DRIVER   | 24 200  4c. County of  Talbo of Birth hth, Day, Year) Y 10, 1915            | Death  1. L  3. Birthplace (State or Foreign Country) W VA   |
|--|---|--|
| Physician /Medical Examiner  Nile A. Stalnaker  4a. Facility Name (If not institution, give street and number)  The Pines Genesis HealthCare Easton  5. Social Security Number 235–16–1974  Usual Residence of Decedent  Month  4b. City, Town, or Location of Death  Easton  1f Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.   JULX   | th Day Y.  24 200  4c. County of  Talbo  of Birth nth, Day, Year) Y 10,1915 | 7 11:30a M Death |
| NITE A. Stallnaker   Q7  | 4c. County of  Talbo of Birth tith, Day, Year) Y 10, 1915                   | Death  1   |
| 4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  The Pines Genesis HealthCare  Funeral Director  5. Social Security Number 235-16-1974  Usual Residence of Decedent  4b. City, Town, or Location of Death  Easton  If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.   JULY    Usual Residence of Decedent  | Talbo of Birth http. Day, Year) Y 10,1915                                   | 9. Birthplace (State or Foreign<br>Country)<br>W VA  |
| Funeral Director  5. Social Security Number 235-16-1974  Usual Residence of Decedent  6. Sex 7. Age (In yrs. last birthday) 92 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date (Months Days Hours Min. JULY)   | of Birth (th, Day, Year) Y 10, 1915   | 9. Birthplace (State or Foreign<br>Country)<br>W VA  |
| Usual Residence of Decedent  | 10g. Citizen of Wha   | W VA   |
|  | -   | 404 1 11 00 11 0   |
| MD TALBOT EASTON  10e. Street and Number  809 N. WASHINGTON ST.  21601  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  8 No Truck Driver  18 Mother's Name (First Middle Last)  18 Mother's Name (First Middle Last)  | -   | 10d. Inside City Limits  |
| MD IALBOI EASTON  10e. Street and Number  809 N. WASHINGTON ST.  21601  11. Marital Status  1 Never Married 2 Married  1 Never Married  1 Never Married 2 Ma | -   | 1 ∑XYes 2 ☐ No   |
| 809 N. WASHINGTON ST.  21601  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  17 Father's Name (First Middle Last)  18 Mother's Name (First Middle Last)  | -   | iat Country?   |
| The state of the s |   | USA  |
| Ammed Forces?    The part of t |   | - American Indian,   |
| 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle, Last)  18. Mother's Name (First Middle, Last)   | tc.) Black, Specify:  | White, etc. WHITE  |
| 15. Decedent's Education  (Specify only highest grade completed)  Elementary/Secondary (0·12)  8  College (1-4or 5+)  8  TRUCK DRIVER  18. Mother's Name (First Middle Last)   | 16b, Kind of Busin  |  |
| Elementary/Secondary (0-12)  College (1-4or 5+)  TRUCK DRIVER  18 Mother's Name /First Middle Last)  | 18b. Kirid of Busii   | nessindustry   |
| 17 Father's Name (First Middle Last)  18 Mother's Name (First Middle Last)   | DEI   | LIVERY   |
|  |   |  |
| Tr. Father's Name (First, Middle, Last)  HENRY S. STALNAKER  MARY M.   |   |  |
| HENRY S. STALNAKER  MARY M.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route)   |   | tato Zin Codol   |
| 병명 보기 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route  | -   |  |
| ESTHER R. FOOTE/DAUGHTER 809 N. WASHINGTON ST., EA   | ASTUN, MD ZI<br>20c. Location - Ci  |  |
| 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)   | 20c. Eduation - Ci  | ity of Town, State   |
| 20a. Method of Disposition  1  | 200 <mark>7 STEVEN</mark>   | NSVILLE, MD  |
| 21. Signature of Funeral Service Licensee  22. Name and Address of Facility FELLOWS, HELFENBEIN & I  | NEUMAM EUMEE  | AT HOME DA   |
| BEEFER W. Ustrawsky C.F.S. PELLOWS, HELFERBEIN & I   | NEWNAM FUNER<br>ASTON, MD 21  | IAL HOME PA  |
| 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respira  | atory arrest,   | Approximate<br>Interval Between  |
| shock, or heart failure. List only one cause on each line:   |   | Onset and Death  |
| disease or condition a   |   | gens   |
| Medical Due Mor y a consequence of):   |   | news   |
| 5 Squartitally list conditions,  Due to (or as a consequence of):  |   | 1  |
|  |   | Maanl  |
| Cause (Disease or injury that initiated events c. Due to (or as a consequence of):   |   | geers  |
|  |   |  |
| in the part of the |   |  |
| description of the property of |   |  |
| 23c. If yes, outcome of pregnancy  23b. Was decedent pregnant  1 Live birth  2 Fetal death  3 Ectopic pregnancy  | 23d. Date   |  |
| in the past 12 months?    Compared to the past 12 months?   Compared to the past 12 months   Compared to the past  | Month   | h Day Year   |
| the state of the   |   |  |
| 1   Yes 2   No 9   Unknown 9   Unknown 200   | a. Did tobacco use contrib  | oute to the cause of death?  |
|  | 1 ☐ Yes 2 📉 No 3  | B ☐ Probably 4 ☐ Unknown   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  236  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  248  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | a. Whas an 24b. We  | ere autopsy findings available   |
| white the property of the prop | autopsy pric  | ior to completion of cause of eath?  |
|  |   | Yes 2□ No  |
| 25. Was case referred to medical 26. Place of Death (Check   | conly one)  |  |
| 2 EP/Outpatient 3 DOA Nursing Home 5   | Residence 6 Other   | (Specify)  |
| 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Des   | scribe how injury occurred  | d  |
| 27. Manner of Death   The property of the prop |   |  |
| The second secon | ation (Street and Number or Town, State)                                    | or Rural Route Number,   |
| a to a control of the | , 5,  |  |
| 7 4 4 6 11 11  | to the cause(s) and manr  | ner as stated.   |
| 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due  | e time, date and place, an  | id due to the cause(s)   |
| 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due (Check only (Check only 2) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the  | 29d. Date signed (  | (Month, Day, Year)   |
| 29a. Certifier (Check only (Check only and Coursed at the time, date and place, and due and place). To the best of my knowledge, death occurred at the time, date and place, and due and place and place and due and due a | 1.76.   | DF   |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the and manner stated.  | 72  | (a.7 /   |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier and manner stated.  29c. License number  |   |  |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier and manner stated.  29c. License number  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  |   |  |
| 29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier (20c)  29b. Signature and ditle of certifier (20c)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Michael Crowley (20c)  40 Dutchmans Lane Easton  | Maryland 2  | 1601   |
| 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due concerns the control of the contr | Maryland 2  | 1601   |

Division of Vital Records, P.O. Box 68760,

Stalnaker, Nile Baltimore, Maryland 21215-0036

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

|                            |   | -                   | For<br>State<br>Registrar   | State of Ma  | -                                    | ertificate of L                               |                        |                              | g. No.  |  |
|----------------------------|---|---------------------|---|--|--------------------------------------|---|------------------------|------------------------------|---|--|
|                            |   |                     | 1. Decedent's Name (First, Middle, Last)  |  |                                      |   |                        |                              |   | 3. Time of Death                               |
| 1                          | Physicia<br>/Medic  |                     | Carl  | Sto  | rankl                                | <u>e</u>                                      |                        | August                       | 4 2007  | 7:15 a <sup>M</sup>                            |
|                            | Examin  |                     | 4a. Facility Name (If not institution, give   | street and number)   |                                      | 4b. City, Town, or                            | Location of Death      |                              | 4c. County of Death                             | _  |
|                            |   |                     | College View C  |  | (In yrs. last birthda                | Frederi  If Under 1 Year                      | ck<br>If Under 24 Hrs. | 8. Date of Birth             | Frederic  | nlace (State or Foreign                        |
|                            | Funeral<br>Director   |                     | 5. Social Security Number 6. S 135-44-1485 Usuel Residence of Decedent  | M 2□F  | 57 Yrs.                              | Months Days                                   | Hours Min.             | (Month, Day,<br>Aug. 1       | Year) Cou<br>1950 Ma                            | place (State or Foreign<br>ntry)<br>aryland    |
|                            | aryland<br>show<br>det  |                     | 10a. State 10b. County  |  | 10c. City, Town or                   | Location                                      |                        |                              |   | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No         |
|                            | 8a-f  | ecto                | Maryland Washing  | ton  | Hag                                  | erstown<br>10f. Zip Code                      |                        | 10                           | ng. Citizen of What Cou                         |  |
|                            | with the  | 늅                   | 10e. Street and Number  | D41- #0  |                                      | 217   | 7/10                   |                              | USA   |  |
|                            | eath  | eral                | 10820 Downsville  | 12. Was Decedent 8   | ver in U.S. 1                        | 3. Was Decedent of Hi<br>If Yes, specify Cuba |                        | ecify Yes or No-             | 14. Race - Amer                                 |  |
| 36                         | ges 1 and 2 should be filed within 72 hours after death with the Maryland to C Health and Mentat Hygiene. If Item 27 is marked other then "natural", or Itams 23a or 28a-f show or other traumatic event, Ita Medical Evaritral must be notified at | by Funeral Director | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  | Armed Forces?  1 Tyes 2 N  1 Yes, Give Year or Dates:              | lo                                   | If Yes, specify Cubar<br>1 ☐ Yes 2 ☐ No       |                        | Rican, etc.)                 | Black, White Specify:                           | , etc.<br>White                                |
| 9                          | 2 hou   | ted                 | 15. Decedent's Ed   | lucation   | 16a De                               | cedent's Usual Occupa                         | ation                  | (inc                         | 16b. Kind of Business/Ir                        |  |
| 21215-0036                 | within 7<br>ene.<br>then "n   | Completed           | (Specify only highest gra<br>Elementary/Secondary (0-12)  | College (1-4or 5   | +) (Gi                               | ve kind of work done of DO NOT use retired    | )                      | ang                          |   | _  |
|                            | filed wil<br>Hygien<br>other th   | Con                 | 12  | 0  | Di                                   | etary work                                    |                        | 75° A 84°444 B               | Hospita   | al   |
| nd                         | 2 should be filed within and Mental Hygiene. Is marked other then aumatic event, I'm Me   | Be                  | 17. Father's Name (First, Middle, Last,   |  |                                      |   |                        | e (First, Middle, M          | naiden Sumame)                                  |  |
| Zla                        | should<br>ind Men<br>ind marke<br>umaric  | ဥ                   | Carl William Spra   |  | 10h M                                |   | Dorothy                |                              | City or Town, State, Zi                         | in Code)                                       |
| Maryland                   | d 2 st<br>th and<br>7 Is n<br>traun   |                     | 19a. Informant's Name/Relationship (  |  |                                      | 320 Downsvi                                   |                        |                              | erstown, Me                                     |  |
|                            | permit. Pages 1 and 2<br>Department of Health a<br>Important: If Item 27 It<br>sny injury or other tra<br><u>once</u> .   |                     | Cindy Sprankle -  20a. Method of Disposition  |  | 20b. Place of Dis                    | position (Name of rematory or other place     |                        |                              | 20c. Location - City or T                       |  |
| Baltimore,                 | ages<br>ant of<br>tr: If II   |                     | t XBurial 2 ☐ Cremation 3 ☐ *4 ☐ Donation 5 ☐ Other (Specif   |  |                                      | awn Mem. P                                    | ·                      | 07 I                         | Hagerstown,                                     | Maryland                                       |
| Ħ                          | artme<br>ortan<br>injur   |                     | 21. Signature of Funeral Service Licer  |  | yeur i                               | 22. Name and Address                          |                        |                              | Funeral Ho                                      |  |
| Ö                          | Depared Impo  |                     | Scottlh.  | Tunka  | 415 E. Wil                           | lson Blvd                                     | . Hagers               | town, Mary                   | land 21740                                      |  |
|                            | 12.5  |                     | 23a. Part 1. Enter the disease or com<br>shock, or heart failure. List only   | plications that caused<br>one cause on each lin                    | the death. Do not                    | enter the mode of dyin-                       | g, such as cardiac     | or respiratory arre          | est,  | Approximate<br>Interval Between                |
|                            | Physician   |                     | Immediate Cause (Final disease or condition   | Cre  | 1+2+0                                | dt - To                                       | acoh                   | disea                        | 254   | Onset and Death                                |
|                            | /Medical  |                     | resulting in death)   | Due to (or as  | a consequence of):                   |   |                        |                              |   |  |
|                            | Examiner  |                     | Sequentially list conditions,   | b  |                                      |   |                        |                              |   |  |
|                            | be sit  | ine                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as  | a consequence of):                   |   |                        |                              |   |  |
|                            | icate be executed<br>physician and<br>s the burial-transit  | Examiner            | that initiated events<br>resulting in death) Last   | cDue to (or as   | a consequence of):                   |   |                        |                              |   |  |
| 68760,                     | sician<br>buris   |                     |   | 4  |                                      |   |                        |                              |   |  |
| 687                        | tificate<br>ng phys<br>as the   | edical              |   | d  |                                      |   |                        |                              |   |  |
| Box                        | res that the death certificate be executed signed by the attending physician and be detached for use as the burial-transit  | Physician/M         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome<br>1 Live birth<br>4 Pregnant at<br>9 Unknown | 2 Fetal death                        | 3 □Ectopic pregnancy<br>5 □ Other (specify)   |                        |                              | 23d. Date of delined Month                      | very<br>Day Year                               |
| P.0                        | that tied by  | / Ph                | Part II, Other significant conditions   | contributing to death b  | ut not resulting in th               | underlying cause give                         | en in Part I.          | 23e. Did tob                 | pacco use contribute to                         | the cause of death?                            |
| ds                         | requires<br>een sign<br>sould be  | d by                |   |  |                                      |   |                        | 1 □ Ye                       | es 2 No 3 Pro                                   | bably 4 Unknown                                |
| <u>0</u>                   | - 0 70  | Completed           |   |  |                                      |   |                        | 24a. Was ar                  | n 24b. Were au                                  | topsy findings available ompletion of cause of |
| Re                         | The law<br>ate has<br>page 2 s  | шо                  |   |  |                                      |   |                        | autops<br>perform<br>1 Yes 2 | ned? death?                                     |  |
| ita                        | ician: Th<br>certificate<br>rector, pag   | 0                   | 25. Was case referred to medical  |  |                                      |   | 26. Place of Dea       | th (Check only on            |   |  |
| f V                        | Physician:<br>this certific<br>ral director,  | To B                | examiner? 1 — Yes 2 — No  | Hospital:<br>1 ☐ Inpatie   | nt 2 ER/Outpa                        | tient 3 DOA Oth                               | er: 4 Nursing H        | ome 5 🗆 Reside               | ence 6 Other (Spec                              | eity)  |
| 0                          | if a  |                     | 27. Manner of Death  1 Natural 5 Pending  | 28a. Date of Inju<br>(Month, Da                                    | ry 28b. Tim<br>y Year) Inju          | y Wor   |                        | 28d. Describe ho             | w injury occurred                               |  |
| sio                        | Attending<br>r death.<br>ector: After<br>by the fune  | cati                | 2 Accident investigation 3 Suicide 6 Could not be   |  |                                      |   | Yes 2 □ No             | 206 Leasting (Ct             | ment and Number or Du                           | m/ Route Alumber                               |
| Division of Vital Records, | or At<br>after d<br>Direct<br>in by   | Certification;      | 4 Homicide determined   | 28e. Place of Ing<br>building, et                                  | ury - At home, farm,<br>c. (Specify) | street, factory, office                       |                        | City or Town                 | reet and Number or Ru<br>n, State)              | rai Houle Number,                              |
| _                          | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu  | edical Co           | (Check only 2 Medical Exa   | miner: On the basis of   | examination and/o                    |   |                        |                              | ause(s) and manner as<br>ate and place, and due |  |
|                            | thin 2<br>the<br>the<br>mplet   | Med                 | one) 29b. Signature and title of certifier  | and manner sta   | 2160.                                | 29c. Licens                                   | e number               | 2                            | 9d. Date signed (Montl                          | n, Dey, Year)                                  |
|                            | T S   |                     |   | e MAK  |                                      |   | 06041                  |                              | 8/6/2   |  |
|                            |   |                     | 30. Name and address of person who  | completed cause of d   | eath (Item 23a) (Tv                  | ne Print)                                     |                        |                              | 1-1/  |  |
| 03                         | H-4-1   |                     | Hemen Shah  | 650  | Thoma                                | 5 Tohn  | son hi                 | Free                         | device N  | 15 21702                                       |
|                            | Sta   | ate                 | 31. Date filed (Month, Day, Year)   | 32. Registr  | ar's Signature                       | 1   |                        | 1                            |   |  |
|                            | Regist  |                     | AUG 0 6 2   | 007 Base   | m B.                                 | Joseph  |                        |                              |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM/29d, per PHYS 1870 8/16/07 WS.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 2007  $A^{\,\mathsf{M}}$ Rebecca Elizabeth Steele 0745 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurelwood Care Center E1kton Cecil If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 222-05-5345 90 Yrs. March 17, 1917 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Example remarks a cutified at 1 ☐ Yes 2 No Directo Marvland Cecil E1kton 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21921 United States 287 Providence Road Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Public School Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant; If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Cafeteria System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Leroy H. Scott Amanda Rebecca Holland 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1450 Appleton Road, Elkton, Maryland 21921 Michael S. Steele/Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) August 7, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important; If eny Injury or once. 4 □ Donation 5 □ Other (Specify) Sharps Cemetery 2007 Fair Hill, Maryland aure of Funeral Service Licensee 22 Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 21. Signa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Alterosclerolic Heart Disease Physician years /Medical Examiner typertension

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ecords, P.O. Box 68760, & led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Onknown this certificate as been si al director, page 2 shruld Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death | Check only one 1 ☐ Yes 2 ☑ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred al or Attending P after death. I Director: After t d in by the funera After 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tipp of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 10023322 achder S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S.S. SACTOEV MD, 18Norts 8t Suite 3B ECK Timmo 21921 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

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Division of Vital

**ORIGINAL** 

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                            |  |  | 1 - For<br>State<br>Registrar   | State of Man                                      | •                                | artment of I<br>rtificate of   |                            | nd Mental Hy                                 | giene<br>Reg. No. | 107                         | 25445   |
|----------------------------|--|--|---|---|----------------------------------|--|----------------------------|--|-------------------|-----------------------------|---|
|                            | Physici  | an                                     | Decedent's Name (First, Middle, La<br>Gordon James Turi   | *   |                                  |  |                            | 2. Date of De<br>Month                       | Day               | Year                        | 3. Time of Death                              |
|                            | /Medio   |  | 4a. Facility Name (If not institution, give   | e street and number)                              |                                  | 4b. City, Town, o  | or Location of             |  | 8, 2007 12:00a A  |                             |   |
|                            |  | ************************************** | 22743 Almost Near  5. Social Security Number 6. S   |   | n con local hinth doc.           | Book of the Book o | ozman                      | 1 Hrs   0 Date of B                          |                   |                             | 1bot  |
| В                          | Funeral Director   |  |   | M 2□F   | n yrs. last birthday)<br>76 Yrs. | Months Days  | Hours                      | Min. 8. Date of Bi<br>(Month, Di<br>June 1   | 9, 193            | 1 New                       | place (State or Foreign<br>ntry)<br>Jersey    |
|                            | land ow  |  | Usuel Residence of Decedent  10a. State 10b. County   | 10  | Dc. City, Town or Lo             | cation   |                            |  |                   |                             | 10d. Inside City Limits                       |
|                            | e Mary   | ctor                                   | Maryland Talbo  | ot  |                                  |  | Oxford                     | i  |                   |                             | 1 Tes 2 No                                    |
|                            | with th  | Funeral Director                       | 10e. Street and Number<br>27968 Oxford Rd.  |   |                                  | 10f. Zip Code 216.   | 54                         |  | 10g. Citizer      | of What Cou<br>USA          | •   |
|                            | oma 2  | Inera                                  | 11. Marital Status  | 12. Was Decedent Eve<br>Armed Forces?             |                                  | Was Decedent of I  | Hispanic Origin            | n? (Specify Yes or No<br>Puerto Rican, etc.) |                   | Race - Amen<br>Black, White | can Indian,                                   |
| 36                         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other than "neturel", or Itema 23a or 28a-1 show says figury or other traumatic event, the Medical Examinar must be notified at ODGe. | by Fu                                  | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced  | 1   | 1                                | 1□Yes 2ŪNo   | Specify:                   | , , , , , ,                                  | 1                 | ec <i>ify</i>               | hite  |
| Maryland 21215-0036        | 72 hou   | eted                                   | 15. Decedent's Ed<br>(Specify only highest gra  | ducation<br>de completed)                         | (Give                            | dent's Usual Occup   | during most o              | of working                                   | 16b. Kind         | of Business/Ir              |   |
| 121                        | within<br>iene.<br>then  | Completed                              | Elementary/Secondary (0-12)   | College (1-4or 5+)                                |                                  | oo not use retire<br>Baker   | nd)                        |  | Cott              | age In                      | duetry  |
| nd                         | be filled<br>tal Hyg<br>d othsi  | BeC                                    | 17. Father's Name (First, Middle, Last)   |   | -                                | Janez  |                            | s Name (First, Middle                        | , Maiden Su       |                             | dustry  |
| ryla                       | hould I  | ၉                                      | Stanley Turnbull  |   | 19b Mailir                       | ng Address /Street   |                            | nice Gilmou                                  |                   | wn State Zi                 | 7 Code)                                       |
|                            | and 2 saith ar n 27 le   |  | Erica Weick/Spou  | ** .  |                                  |  |                            | Oxford, M                                    |                   |                             |   |
| Baltimore,                 | tges 1<br>of He<br>or oth  |  | 20a. Method of Disposition 1 Durial 2 Cremation 3 D   | Removal from State                                | -                                | natory or other pla  | . 1                        | Date   |                   | ion - City or T             |   |
| altin                      | mit. Pa<br>bartmer<br>sortant<br>/ Injury  |  | 4 □ Donation 5 □ Other (Specify Signature of Fundary States and S |   | MidShore(                        | Cremation  | Center                     | 8.8.2007                                     | Camb              | ridge,                      | MD  |
| ä                          | F 0 E 6  |  | fagles three  | t- Som  | ion Center<br>Cambridge          | r, PO<br>≘, MD   | Box 14<br>21613            | 64,  |                   |                             |   |
|                            | Physician  |  | 23a Part 1. Enter the disease, or com<br>shock, or heart latture. List only<br>Immediate Cause (Final<br>disease or condition   | one cause on each line.                           | e death. Do not ent              | Juent (  | ng, such as ca             | ardiac or respiratory a                      | rrest,            |                             | Approximate Interval Between Onset and Death  |
|                            | /Medical<br>Examiner   |  | resulting in death)   | Due to (or as e co                                |                                  |  |                            |  |                   |                             |   |
|                            | po iis   | iner                                   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | b. Due to (or as a ci                             | onsequence of):                  |  |                            |  |                   |                             |   |
| 9                          | execute<br>n and<br>al-trans   | Examiner                               | that initiated events resulting in death) Last  | c. Due to (or as a co                             | onsequence of):                  |  |                            |  |                   | -                           |   |
| 8760,                      | cate be executed<br>obysician and<br>the burial-transit  |  |   | d. =  |                                  |  |                            |  |                   |                             |   |
| Box 6                      | eath certific<br>attending pl  | /Mec                                   | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome of p                         | pregnancy                        |  |                            |  | 23d               | . Date of deliv             | en  |
| P.O. Bo                    | that the death<br>led by the atter<br>detached for i   | Physician/Medical                      | in the past 12 months?  1  Yes 2 No 9 Unknown   | 1□Live birth 2□<br>4□Pregnant at tim<br>9□Unknown |                                  | Ectopic pregnanc<br>Other (specify) _  | у                          |  |                   | Month                       | Day Year                                      |
|                            | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit   | þ                                      | Part II. Other significant conditions of  | ontributing to death but n                        | ot resulting in the u            | nderlying cause giv  | ven in Part I.             | _  | Yes 2XN           |                             | the cause of death?                           |
| eco                        | ne law rec<br>has bee<br>ge 2 shor   | Completed                              |   | 9   |                                  |  |                            | 24a. Was                                     |                   | 4b. Were aut                | opsy findings available ompletion of cause of |
| E<br>E                     | ician: The<br>certificate h  | e Con                                  | OS Was soon referred to made al   |   |                                  |  |                            | perfe<br>1 ☐ Yes                             | 2 No              | death?                      | 2 🗆 No  |
| Ž                          | Physician:<br>r this certifica<br>ral director, I  | To Be                                  | 25. Was case referred to medical examiner? 1 \( \text{Yes}  \text{No} \)  | Hospital:   | 2 ER/Outpatier                   | t 3 DOA Ott  |                            | ing Home 5 Res                               |                   | Other (Speci                | Friend's                                      |
| o uc                       | ding Pt<br>h.<br>After th<br>funeral   |  | 27. Manper of Death 1 Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Ye             | ear) 28b. Time of Injury         | Wo   | ryat<br>rk?<br>]Yes 2 □ No | 28d. Describe                                | how injury or     | ccurred                     | 1100101140                                    |
| Division of Vital Records, | Attender deat  | Certification:                         | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined   | 1   | - At home, farm, str             |  | 1165 2 1140                | 28f. Location (                              | Street and N      | umber or Rur                | al Route Number,                              |
| Ξ                          | Hospital or<br>24 hours afte<br>Funeral Dir<br>stely filled in   |  | 29a. Certifier 1 Certifying Ph  | ysician: To the best of m                         |                                  |  | data and                   |  |                   |                             |   |
|                            | To the Hospital within 24 hours a To the Funeral completely filled   | edlcai                                 | (Check only 2 Medical Examone)  | niner: Of the basis of ex<br>and manner stated    | amination and/or in              | vestigation, in my   | opinion, death             | occurred at the time,                        | date and pla      | ace, and due                | to the cause(s)                               |
|                            | To the within 2 To the complete  | Σ                                      | 29b. Signature and title of certifier   |   |                                  | 29c. Licens  |                            |  | 29d. Date s       | igned (Month,               | Day, Year)                                    |
| r                          | . ^  |  | 30. Name and address of person who  | completed cause of death                          | h (Item 23a) (Type,              |  | 4270                       |  | 0/0               | 101                         |   |
|                            | 10   | <b>3</b>                               | David C. Halverso   | n, M.D., 82                                       | 21 Teal D                        | r., Suit   | e 302,                     | Easton, N                                    | D 216             | 501                         |   |
| 0.00                       | Sta<br>Registr   |  | AUG 1 6 20  | 32 Registrar's                                    | It Spa                           | de   |                            |  |                   |                             |   |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10, 2007 August 6:26 RALPH EARL THOMAS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Air Harford Bel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1**∑**M 2□F 268-20-4928 84 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Harford MD. Fallston 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21047 2215 Baldwin Mill Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗓 No Specify: Completed by 3X Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15, Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College\_(1-4or 5+) Custodian College 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Henry Lewis Thomas Josephine Etta 2 Meisner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21047 2215 Baldwin Mill Rd. Thomas/Brother Wardell L. Fallston, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) = 5 permit. Page Department of Important: If any Injury or once, Jarrettsville Cem. 8/14/2007 Jarrettsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jarrettsville, Maryland 21. Signature of Funeral Service Licensee E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death letastatic Prostate Immediate Cause (Final years Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence of burial-trai Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed in page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

within 24 hours after death

To the Funeral Director:
completely filled in by the

filed within 72 hours after death with the Maryland

be

Pages 1 and 2 should

6 ☐ Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 North Ave. Bel Air, Md. 21014.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated.

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D35012 29d. Date signed (Month, Day, Year)

State Registrar

3

LYN Keyin 31. Date filed (Month, Day, Year) 32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 12:00 PM Robert L. Twine, 27, 2007 Ju1v 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 25925 Largo Court Montgomery Damascus 6. Sex 1 M 2 ☐ F If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 223-52-5997 66 6, 1941 Jan. Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Damascus 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20872 25925 Largo Court U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Electrical Elementary/Secondary (0-12) College (1-4or 5+) Electrician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert L. Twine, Sr. (Unknown) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Anthony Twine - Son 207 West Cook, Street, Portage, Wisconsin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 8/7/07 Metropolitan Crematorium 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia 21. Signature of F neral Service Licensee 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home Noveri 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DISEASO pronance Vears Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 0/00 ancer 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 XNo 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA

**Physician** /Medical Examiner Examine

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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"natural", or Items 23a or

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permit. Pages Department of I Important: If Ite any injury or of

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

burial-trar the as attending properties for use as been signed by the a should be detached f has page 2 certificate ector,

Physician/Medical

Completed by

Be

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Certification:

Medical

State

Registrar

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician; after death filled in by the within 24 hours a To the Funeral I

Natural 2 Accident 5 ☐ Pending investigation 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide determined 29a. Certifiei

27. Manner of Death

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and itle of certifier

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my oninjon, death occurred at the time, date and place, and due to the

28b. Time of

Injury

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 7/30/07

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert DiBianco, M.D. 15215 Shady Grove Road, Rockville, Maryland

31. Date filed (Month, Day, Year) 2007

i) BANCO

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|               |   |                | 1 - For<br>Registrar  | State of Ma                           | aryland /         |                       | rtment e<br>tificate            |                         |                               | d Mental                              | Hygier                  |                                      | 26443                               |  |
|---------------|---|----------------|---|---------------------------------------|-------------------|-----------------------|---------------------------------|-------------------------|-------------------------------|---------------------------------------|-------------------------|--------------------------------------|-------------------------------------|--|
|               | \$ .5   |                | Decedent's Name (First, Middle, Last,   |                                       |                   |                       | 2. Date of                      |                         |                               |                                       |                         |                                      |                                     |  |
|               | Physici   |                | Frederick Calver  | t Wiebe                               | l Sr.             |                       |                                 |                         |                               | Month                                 |                         | Day Year<br>0,2007                   | 7:20 A. M                           |  |
|               | /Medi<br>Examir   |                | 4a. Facility Name (If not institution, give   |                                       |                   |                       | 4b. City, To                    | wn, or Lo               | cation of D                   |                                       |                         | 4c. County of Dea                    |                                     |  |
| 988           | LAUIIII   | iei            | 18808 Preston Rd.   |                                       |                   |                       | Hagerstown                      |                         |                               |                                       |                         | Washin                               | aton                                |  |
| - 27          | Funeral   |                | 5. Social Security Number 6. Se   |                                       | e (In yrs. last b | irthday)              | ff Under 1                      | rear If                 | Under 24 I                    | Hrs. 8. Date o                        | f Birth                 | 9. Bi                                | rthptace (State or Foreign          |  |
|               | Director  |                |   | M 2□F                                 | 82                | Yrs.                  | Months D                        | ays F                   | Hours N                       | Ain. (Montr                           | 10 ,                    | ar) C                                | ountry)                             |  |
|               |   |                | Usual Residence of Decedent   |                                       |                   |                       |                                 |                         |                               | lo une                                | 10,                     | 1723                                 | Maryland                            |  |
|               | ylan  |                | 10a. State 10b. County  |                                       | 10c. City, Tov    | vn or Lo              | cation                          |                         |                               |                                       |                         |                                      | 10d. fnside City Limits             |  |
|               | Mar.  | to             | Maryland Washing  | ton                                   |                   |                       | $H_{\epsilon}$                  | agers                   | stown                         |                                       |                         |                                      | 1 ☐ Yes 2 ☐ No                      |  |
|               | r 28g   | Directo        | 10e. Street and Number  |                                       |                   |                       | 10f. Zip Co                     | ode                     | -                             | -                                     | 10g. (                  | Citizen of What C                    | ountry?                             |  |
|               | hours after death with the Maryland<br>tural, or Items 23e or 28e-f show<br>at Exercitivating to notified at  |                | 18808 Preston Re  | oad                                   |                   |                       |                                 | 217                     | 742                           |                                       |                         | U.S.A.                               |                                     |  |
|               | deat<br>ms 2  | Funeral        | 11. Marital Status  | 12. Was Decedent                      | Ever in U.S.      | 13. V                 | Vas Deceden                     | t of Hispa              | anic Origin                   | ? (Specify Yes o                      | r No-                   | 14. Race - Am                        | erican Indian,                      |  |
| 9             | or ite  | F              | 1 Never Married 2 Married   | Armed Forces?                         | NO WWII           |                       |                                 |                         |                               | uerto Rican, etc.                     | .)                      | Black, Whi                           | te, etc.                            |  |
| 8             | all, o  | by             | 3  Widowed 4 Divorced   | ff Yes, Give<br>Year or Dates:        |                   | 1                     | ☐ Yes 2页                        | (No S                   | Specify:                      |                                       |                         | Specify:                             | White                               |  |
| 15-0036       | 72 ho   | Completed      | 15. Decedent's Edu  | cation                                | 168               | . Deced               | ent's Usual C                   | ccupatio                | n                             |                                       | 16b.                    | Kind of Business                     | /Industry                           |  |
| 2             | filed within 72<br>Hygiene.<br>ther then "naither, if e M. Jic.   | ple            | (Specify only highest grade   | Colfege (1-4or 5                      | (+)               | lite. C               | kind of work of<br>OO NOT use   | one aurii<br>etired)    | ng most of                    | working                               |                         |                                      |                                     |  |
| 21            | gien<br>gien  | ρ              |   | 4                                     |                   |                       | Sales                           | sman                    |                               |                                       |                         | Door C                               | ompany                              |  |
| ğ             | m - 0 5   | Be             | 17. Father's Name (First, Middle, Last)   |                                       |                   |                       |                                 | 18                      | . Mother's                    | Name (First, Mi                       | ddle, Maid              | en Sumame)                           |                                     |  |
| ā             | should be<br>nd Mental<br>marked o  | To E           | Frank G. Wiebel   | 1                                     |                   |                       |                                 |                         | $L_{i}$                       | illian E                              | 3. Gr                   | ubbs                                 |                                     |  |
|               | S D E E   |                | 19a. Informant's Name/Relationship (Ty  | oe, Print)                            | 19                | b. Mailin             | g Address (S                    | treet and               |                               |                                       |                         | y or Town, State,                    | Zip Code)                           |  |
|               |   |                | Patricia A. Wiebel  | l (Wife                               | e) 1              | 8808                  | Prest                           | on F                    | Rd. Ha                        | agerston                              | m, M                    | aryland                              | 21742                               |  |
| altimore,     | s 1 and<br>if Healt<br>item 2<br>other i  |                | 20a. Method of Disposition  |                                       | 20b. Place        | of Dispos             | sition (Name                    | of                      |                               | Date                                  | 20c.                    | Location - City or                   |                                     |  |
| ဠ             |   |                | 1 ☐ Burial 2 【X Cremation 3 ☐ R<br>4 ☐ Donation 5 ☐ Other (Specify)   | emoval from State                     |                   | -                     | g Cren                          |                         | $A\iota$                      | igust 11                              | ,                       | Smithchu                             | rg, Maryland                        |  |
| Ξ             |   |                | 21. Signature of Funeral Service License  | 90                                    | DINIT CIT         |                       | Name and A                      |                         | -                             | 2007                                  | _                       |                                      |                                     |  |
| ä             | permit. Departr Importu any inj   |                | T-CC-   |                                       | 44014/11          |                       |                                 |                         |                               |                                       |                         | vis Fune.                            |                                     |  |
|               |   |                | 23a Parti. Enter the disease, or compli   |                                       | MO14/4            |                       |                                 |                         |                               |                                       |                         | rg, Mary                             | land 21783 Approximate              |  |
|               |   |                | snock, or neart failure. List only or   | e cause on each lin                   | 10.               | 1                     |                                 |                         | 1                             |                                       | ry arrest,              |                                      | Interval Between<br>Onset and Death |  |
| F             | hysician  |                | Immediate Cause (Final disease or condition resulting in death)   | 40                                    | vance             | 4                     | De                              | M                       | wh                            | a                                     |                         |                                      | Shock and Educati                   |  |
|               | /Medical<br>Examiner  |                | resolung in dealin)   | Due to (or as                         | a consequence     | of):                  |                                 |                         |                               |                                       |                         |                                      |                                     |  |
|               | ***   |                | Sequentially list conditions,   |                                       |                   |                       |                                 |                         |                               |                                       |                         |                                      |                                     |  |
| 0             | D #   | ine            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as                         | a consequence     | of).                  |                                 |                         |                               |                                       |                         |                                      |                                     |  |
| ~             | acute<br>ind<br>trans   | Examine        | that initiated events resulting in death) Last  |                                       |                   |                       |                                 |                         |                               |                                       |                         |                                      |                                     |  |
| Š             | be exectician and burial-tra  | ũ              | resulting in death) Last  | Due to (or as                         | a consequence     | of):                  |                                 |                         |                               |                                       |                         |                                      |                                     |  |
| 09/8          | cate be executed<br>physician and<br>the burial-transit   | dlcal          |   |                                       |                   |                       |                                 |                         |                               |                                       |                         |                                      |                                     |  |
|               | ng p  | Med            | IF FEMALE:  |                                       |                   |                       | 5 POF 16 PO                     |                         |                               |                                       | -                       |                                      |                                     |  |
| X<br>Q        | death certifi<br>e attending<br>ed for use as   | Physician/Me   | 23b. Was decedent pregnant 2  | 3c. If yes, outcome<br>1 ☐ Live birth |                   | 3 🗆                   | Ectopic pregr                   | ancv                    |                               |                                       |                         | 23d. Date of de                      | •                                   |  |
|               | dea<br>ne att   | SICI           | in the past 12 months? 1 Yes 2 No   | 4☐Pregnant at<br>9☐ Unknown           |                   |                       | Other (special                  |                         |                               |                                       |                         | Month                                | Day Year                            |  |
| S.            | at the<br>by the<br>tache   | h              | 9 Unknown   | 9LI ONKHOWII                          |                   |                       |                                 |                         |                               |                                       |                         |                                      |                                     |  |
| ś             | requires that the death certifi<br>een signed by the attending f<br>nould be detached for use as  | by F           | Part II. Other significant conditions con   | tributing to death be                 | ut not resulting  | in the un             | derlying caus                   | e given ir              | Part I.                       | 23e. [                                | oid tobacco             | o use contribute t                   | o the cause of death?               |  |
| <u> </u>      | = v n   |                |   |                                       |                   |                       |                                 |                         |                               | _   1                                 | ☐ Yes                   | 2 2 No 3 P                           | robably 4 Unknown                   |  |
|               | > Q to  | Completed      |   |                                       |                   |                       |                                 |                         |                               | 24a. V                                | Vas an                  | 24b. Were a                          | utopsy findings available           |  |
|               | 0 - 0   | E              |   |                                       |                   |                       |                                 |                         |                               | a                                     | utopsy<br>erformed?     | prior to death?                      | completion of cause of              |  |
|               | ician: Th<br>certificate<br>rector, pag   | ပိ             | 25. Was case referred to medical  |                                       | <del></del>       |                       |                                 |                         |                               | 1 🗆 Y                                 |                         | Vo 1 ☐ Yes                           | 2 No                                |  |
| <b>&gt;</b> : | Physician:<br>this certific<br>ral director,  | O B            | examiner?   | ospital:                              | -t 0[]50/0        |                       | aCl =0.                         | Othor                   |                               | Death (Check or                       |                         |                                      |                                     |  |
|               | ding Phys   | -              | 27. Manner of Death   | 28a. Date of Injur                    |                   | Time of               |                                 | l                       | 4 🗌 Nursin                    |                                       |                         | 6 ☐Other (Spe                        | ecify)                              |  |
| G :           | ding<br>P. Afte<br>fune   | tion           | 1 Vatural 5 Pending   | (Month, Day                           |                   | Injury                | м 200.                          | Injury at Work?         | 2 🗆 No                        | 250. 26301                            | 100 11044 111           | lary occurred                        |                                     |  |
| DIVISION      | Attending<br>ir death.<br>ector: After<br>by the fune   | Certification: | 3 Suicide 6 Could not be  | 28e. Place of Inju                    | inc. At home, fo  | arm etro              |                                 |                         |                               | 29f Logatio                           | on /Stroot              | and Number or D                      | ural Route Number.                  |  |
|               | or after<br>Dire  | erti           | 4 Homicide determined   | building, etc                         | . (Specify)       | aiii, 500             | ot, lactory, or                 | iice                    |                               | City or                               | Town, Sta               | ate)                                 | urar noble rediliber,               |  |
| -             | or the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, |                | 29a. Certifier 1 Certifying Phys  | ician: To the best                    | of my knowled-    | o doot-               | nani-mada:                      | ho t                    | data and d                    | 000 000                               | the man                 | (a) and                              |                                     |  |
| :             | Hos<br>24 hc<br>Fun<br>Fun  | edical         | (Check only 2 Medical Exemir  | er: On the basis of<br>and manner sta | examination ar    | e, death<br>nd/or inv | occurred at t<br>estigation, in | ne time, c<br>my opinic | date and plant<br>on, death o | ace, and due to<br>ccurred at the til | the cause<br>ne, date a | (s) and manner a<br>nd place, and du | s stated.<br>e to the cause(s)      |  |
|               | ithin<br>thin<br>the<br>mple  | Med            | 29b. Signature and little of bertifier.   | and maillet sta                       |                   |                       | 290 1                           | cense nu                | ımber                         |                                       | 29A F                   | Date signed (Moni                    | th Day Year)                        |  |
| -             | - ≯ <u>-</u> 8  |                | 0 / - 4 [   | 700                                   | \                 |                       | 1                               |                         | 100                           | 222                                   |                         |                                      | _                                   |  |
|               |   |                | · salle   | Uhmos                                 | 7                 |                       |                                 | 00                      | (D)                           | Y 23                                  |                         | 8/10                                 | 12007                               |  |
|               | 5   |                | 30. Name and address of person who co   | mpleted cause of de                   | eath (Item 23a)   | (Type, F              | Print)                          | Λ                       | 11                            | 10 A CO 1                             | 1                       | ممما                                 | - 710                               |  |
| F.5           |   |                | 21 Date fled (15 at 1)  | man :                                 | 100 10            | DY Y                  | 1 mal                           | KING                    | - 1                           | rough KS                              | MM                      | I) IVU.                              | 21 140                              |  |
|               | Sta<br>Registr  | -              | 31. Date filed (Month, Day, Year)   | 1                                     | r's Signature     | A                     | e                               |                         |                               | 0                                     |                         |                                      |                                     |  |
| 7000          | riegisti  | 21             | AUC 1 6 2007  | 878 J. 1. 24 a                        | 60 4              | 37 375                |                                 |                         |                               |                                       |                         |                                      |                                     |  |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|  | Sharon | Kaye | Walters-Ncentee |
|--|--------|------|-----------------|
|--|--------|------|-----------------|

| Decedents Name (First, Middle, Last)   Decedents Name (First, Middle, Last)  |  | Registrar  |  | Certific                   | ate of L      | Death              |              |                  | Reg. No               | ).                        |                        |
|--|--|--|--|----------------------------|---------------|--------------------|--------------|------------------|-----------------------|---------------------------|------------------------|
| a. Facility-fame (in christmosts), pive stream an number)  30. Secure Security Manufactor (in christmost)  30. Secure Security Manufactor  30. Security Security Manufactor  30. Security Security Manufactor  30. Security Manufactor  30. Security Security Manufactor  30. Security Security Manufactor  30. Security Security Manufactor  30. Security Security Manufactor  30. Security Security Manufactor  40. Security Manufactor  30. Security Security Manufactor  40. Security Manufactor  40. Security Manufactor  40. Security Manufactor  40. Security Manufactor  40. Security Manufactor  40. Security Manufa  | Physician/<br>I Examine  | Decedent's Name (First, Min                                | Kaye Wa                                      | alter                      | s-McEr        | itee               | Mor          | Month Day Year   |                       |                           |                        |
| 213-52-1396   M   2/x   58   Vr.   Months   Day   Mors   Dr.   Mors   Dr.   Program    |  |  |  |                            | 4b            | . City, Town, or   |              | Death            |                       |                           |                        |
| 213-52-1396   M 2   XF   58   Ye.   March 25, 1940   Governor Mary 1.    10- Street and Number   100- County   100 | uneral   |  |  | ge (In yrs. last bir       | rthday)       |                    |              |                  | ate of Birth(MN       | Fore                      | eign                   |
| August 1    |  |  | 1 M 2 XF                                     | 58                         | Yrs.          |                    |              |                  | rch 2                 | 5,1949°                   | Country) Maryla        |
| 3 30 06 Acton Avenue  1  |  | 10a. State 10b. Coun                                       | ty   | 10c. City, Town            | or Location   | 1                  |              |                  |                       |                           |                        |
| 3 30 06 Acton Avenue  1  | a-f sho<br>t once.   |  | Baltimore                                    |                            |               |                    | ille         |                  | 10g Ci                | tizen of M/hat Co         |                        |
| 1. Was Decodered Higher Company Company (1)   1. Was Decodered Higher High Company (1)   1. Was Decodered Higher High Company (1)   1. Was Decodered High Comp   | or 28 iffied a   |  | 6 Acton Ave                                  | anii a                     |               | ioi. Zip Code      | 2122         | 4                | 10g. Ci               | dizen or vynat Co         | ountry?                |
| Secretary Secretary (1922)   Secretary Secretary (1922)   College (14 or 54)   Homemaker   Secretary Secretary (1922)   College (14 or 54)   Homemaker   Secretary Secretary (1922)   College (14 or 54)   Homemaker   Secretary Secretary (1922)   Secretary Secretary Secretary (1922)   Secretary Secretary Secretary (1922)   Secretary Secretary (1922)   Secretary Secretary Secretary (1922)   Secretary Secretary Secretary (1922)   Secretary Secretary Secretary (1922)   Secretary Secretary Secretary Secretary (1922)   Secretary Secretary Secretary Secretary (1922)   Secretary Secretary Secretary Secretary Secretary Secretary (1922)   Secretary Secreta   | nus 23;<br>be not  | 11. Marital Status   | 12. Was Deceder                              | nt Ever in U.S.            |               |                    | panic Origin | n? (Specify Y    |                       |                           |                        |
| Date Method of Disposition (Patients of Disposition (Patients of Commission of Other Specify)  20. Boundary of Tomorphy of Other Specify  21. Signature of Fundament Cemelary.  22. Specific of Disposition (Patients of Commission of Other Specify)  23. Specific of Fundament Chapel, P.  24. Donation 5: Other Specify  25. Part Librer the disease, or commission of Fundament Chapel, P.  26. Part Librer the disease, or commission of Fundament Chapel, P.  27. Signature of Fundament Chapel, P.  28. Part Librer the disease, or commission of Fundament Chapel, P.  29. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Guident Chapel, P.  20. Part Librer the disease or Commission of Guident Chapel, P.  20. | or ite   |  | 1 Yes  | per server                 |               |                    |              | ruerto Rican,    | etc.)                 |                           |                        |
| Date Method of Disposition (Patients of Disposition (Patients of Commission of Other Specify)  20. Boundary of Tomorphy of Other Specify  21. Signature of Fundament Cemelary.  22. Specific of Disposition (Patients of Commission of Other Specify)  23. Specific of Fundament Chapel, P.  24. Donation 5: Other Specify  25. Part Librer the disease, or commission of Fundament Chapel, P.  26. Part Librer the disease, or commission of Fundament Chapel, P.  27. Signature of Fundament Chapel, P.  28. Part Librer the disease, or commission of Fundament Chapel, P.  29. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Guident Chapel, P.  20. Part Librer the disease or Commission of Guident Chapel, P.  20. | amine<br>d by  |  | or Dates:                                    | mpleted) 16a.              | Decedent's    | Usual Occupat      | on (Give kir |                  | ne 16b.               | 1                         |                        |
| Date Method of Disposition    Disposition    | an "na<br>ical Ex  |  | 2) College (1-4 or                           | 5+)                        | during mos    | t of working life. | DO NOT u     | se retired)      |                       | in the object of          |                        |
| Date Method of Disposition (Patients of Disposition (Patients of Commission of Other Specify)  20. Boundary of Tomorphy of Other Specify  21. Signature of Fundament Cemelary.  22. Specific of Disposition (Patients of Commission of Other Specify)  23. Specific of Fundament Chapel, P.  24. Donation 5: Other Specify  25. Part Librer the disease, or commission of Fundament Chapel, P.  26. Part Librer the disease, or commission of Fundament Chapel, P.  27. Signature of Fundament Chapel, P.  28. Part Librer the disease, or commission of Fundament Chapel, P.  29. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease, or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Fundament Chapel, P.  20. Part Librer the disease or commission of Guident Chapel, P.  20. Part Librer the disease or Commission of Guident Chapel, P.  20. | giene.<br>Iher the e Medi  | 12<br>17. Father's Name (First, Midd                       | le Last)                                     |                            | Home          |                    | 8 Mother's   | Name (First      |                       |                           | ie                     |
| Date Method of Disposition of Disposition (Parmy In June 2) and Appeals of Security 1 and 1 and 1 and 1 and 1 and 1 and 1 and 2 and  | rital Hy rked of   | The date of Harris (1 list, Midd                           | ,  | Poid                       |               |                    |              |                  | ,                     | ,                         |                        |
| Date Method of Disabetilion    Date   | is mar   | 19a. Informant's Name/Relation                             | nship (Type, Print)                          | 19                         |               |                    | and Numb     | er or Rural R    | oute Number,          | City or Town, Sta         |                        |
| 1   Burial 2   Cremation 3   Removal from State   Bayview Crematory 8-13-07   Baltimore, Marylan   22   Name and Address of Facility Marzullo Funeral Chapel, P   22   Name and Address of Facility Marzullo Funeral Chapel, P   20   Name and Address of Facility Marzullo Funeral Chapel, P   Application of Control of Part II. Chapel   Part III. Chapel   Part II. Chapel   Part III. Chapel   Part   | ealth a<br>em 27<br>em 27<br>traum   | Lonnie R. Pe   | erry, Jr /Fr                                 | iend 3                     | 006 Z         | Acton              | Road         | Balti            | imore,                | Maryla<br>Location - City | nd21234                |
| 2   Separative of Foreign Service Legensee   22   Name and Address of Facility   23   Name and Address of Facility   23   Name and Address of Facility   24   Donation 5   Donate Speciely   25   Name and Address of Facility   25   Name and Addre   | e E E E  | 1 Burial 2 X Cremat  |  | tate crema                 | tory or othe  | r place)           | - 1          |                  |                       | ,                         |                        |
| Social minor   Soci   | artmer<br>oortan<br>iry or   |  |  | Dayv                       | 22. Nar       | ne and Address     | of Facility  | 3-13-(           | )/  Ba                | Itimor                    | e,Marylan              |
| The trailing of the contributing to death but not resulting in the underlying cause given in Part I.  The trail of the contributing to death but not resulting in the underlying cause given in Part I.  The trail of the contributing to death but not resulting in the underlying cause given in Part I.  The trail of the contributing to death but not resulting in the underlying cause given in Part I.  The trail of the contributing to death but not resulting in the underlying cause given in Part I.  The trail of the contributing to death but not resulting in the underlying cause given in Part I.  The trail of the contributing to death but not resulting in the underlying cause given in Part I.  The trail of the contributing to death but not resulting in the underlying cause given in Part I.  The trail of the contribution of contributing to death but not resulting in the underlying cause given in Part I.  The trail of the contribution of the contribution of the contribution of cause given in Part I.  The trail of the contribution of the contribution of the contribution of cause given in Part I.  The trail of the contribution of the contribution of the contribution of cause given in Part I.  The trail of the contribution of the contribution of the contribution of cause given in Part I.  The trail of the contribution of the contribution of the contribution of cause given in Part I.  The trail of the contribution of the contribution of the contribution of cause given in Part I.  The trail of the contribution of t | a in the part of t | michael F  | Marsello                                     | -                          | - 600         | 9 Hari             | ford         | Road             | Balti                 | neral<br>more.M           | Chapel,P.<br>arvland21 |
| Immediate Cause (Final disease) and immediate Cause (Final disease) and allocation intoxication  | /sician  | 23a. Part I. Enter the disease, failure. List only one cau | or complications that cause se on each line. | d the death. Do n          | ot enter the  | mode of dying,     | such as car  | diac or respir   | atory arrest, sh      | nock, or heart            | Between Onset a        |
| Sequentially list conditions, if any, leading to immediate use (Disease or injury that initiated events resulting in death) Last Use use. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Use use. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Use use of John Control C | aminer   |  |  |                            | one and       | alprazol           | am) and      | d alcoho         | l intoxi              | cation                    | Death                  |
| If any, leading to immediate acase. Enter Inderlying Cause or injury that initiated events resulting in death) Last    Applies of Color of Cause Color of C  | -  | Sequentially list conditions.                              | b.   | sequence or).              |               |                    |              |                  |                       |                           |                        |
| Security    | niner  | cause. Enter Underlying Caus                               | se .   | sequence of):              |               |                    |              |                  |                       |                           |                        |
| Security    | isit   |  |  | sequence of):              |               | _                  |              |                  |                       |                           |                        |
| Part II. Other significant conditions    1   |  | ▼ UNPENDED   |  |                            |               |                    |              | -                |                       |                           |                        |
| Part II. Other significant conditions    1   | ohysici<br>ne buri   | IF FEMALE:   | 23c. If yes, outco                           | ,28a-f, prome of pregnancy | ME,G87        | 0, 8/22/0          | 7 TT         |                  | 2:                    | 3d. Date of delive        | ery                    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of death?   1   Yes 2   No 3   Probably 4   Unknow  |  |  | I Live birti                                 |                            |               |                    | Ectopic p    | oregnancy        |                       | Month                     | Day Year               |
| 1   Yes 2   No 3   Probably 4   Unknown  | the atte   | 1 Yes 2 ✔ No 9 L   | Inknown                                      |                            | 5 Othe        | г (Ѕреслу)         |              | -                |                       |                           |                        |
| whedical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  August 5, 2007  30. Name and address of person who completed cause of death (Item 23a)  | ned by detache   | Part II. Other significant cond                            | ditions contributing to dea                  | th but not resultin        | ng in the und | lerlying cause g   | iven in Part |                  |                       |                           |                        |
| whedical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  August 5, 2007  30. Name and address of person who completed cause of death (Item 23a)  | een sig  | ll   |  |                            |               |                    |              |                  |                       |                           |                        |
| whedical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  August 5, 2007  30. Name and address of person who completed cause of death (Item 23a)  | e has b<br>ge 2 sho<br>mple  |  |  |                            |               |                    |              |                  | autopsy<br>performed? | prior to<br>death         | o completion of cause  |
| whedical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  August 5, 2007  30. Name and address of person who completed cause of death (Item 23a)  | or, pag  | 25. Was case referred to medi                              | cal  |                            |               | 26.Place           | of Death (C  | 1 heck only on   |                       | No 1                      | Yes 2 No               |
| whedical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  August 5, 2007  30. Name and address of person who completed cause of death (Item 23a)  | this ce  |  | Hospital: 1 Inpati                           | ent 2 ER/C                 | outpatient :  |                    | Othor:       |                  |                       | dence 6 🗸 Oth             | ner: Scene             |
| whedical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  August 5, 2007  30. Name and address of person who completed cause of death (Item 23a)  | After funera   | 1 Natural  |  | ury 28b.<br>Year)          | Time of Inju  |                    | _            |                  | escribe how in        | jury occurred             |                        |
| whedical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  August 5, 2007  30. Name and address of person who completed cause of death (Item 23a)  | r death<br>ector:<br>by the  |  | estigation Fnd 8/4/                          |                            |               | DIII               | 21           | CLI              |                       |                           | Durat Davida Nambara   |
| whedical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  August 5, 2007  30. Name and address of person who completed cause of death (Item 23a)  | urs afte   | de de  | ould not be                                  |                            |               | ractory, onice bi  | unaing, etc. | 300              |                       |                           |                        |
| 29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  August 5, 2007  30. Name and address of person who completed cause of death (Item 23a)  | 24 hor etely fil   | 29a. Certifier 1 Certifying                                | Physician: To the best of r                  | ny knowledge, de           | ath occurre   |                    |              | e, and due to    | the cause(s) a        | and manner as st          | ated.                  |
| 30. Name and address of person who completed cause of death (Item 23a)  O.C.M.E. August 5, 2007  | within<br>To the<br>compl-   | 4  | , and manner stated                          | amination and/or i         | investigation |                    |              | urred at the tir |                       |                           |                        |
| 30. Name and address of person who completed cause of death (Item 23a)   | 2  | 290. Signature and title of certi                          | tyer //                                      |                            |               |                    |              |                  | - 1                   |                           | -                      |
|  |  | 30 Natile and address of norm                              | on who completed cause of                    | death (Item 23a)           | -             | 0.0.6              | · · · ·      |                  |                       | guat 0, 2007              |                        |
|  |  |  | SIT THE TOTAL PROPERTY OF THE PROPERTY OF    | ucanı (IICIII Zod)         |               |                    |              |                  |                       |                           |                        |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| narota Wilgita   |                  | 1- For State   | e or iviaryiand /   |                        | e of Death                          | no ivientai r            | • •                                   | eg. No.                            |                              |
|--|------------------|--|---|------------------------|-------------------------------------|--------------------------|---------------------------------------|------------------------------------|------------------------------|
| Physical Exar  |                  |  | ast)<br>Walls   |                        | -                                   | •                        | 2. Date of Deat<br>Month<br>August 7, |                                    | 3. Time of Death<br>1814 hrs |
|  |                  | 4a. Facility Name (if not institution, 329 Red Hill Road                                       | give street and number)                                     |                        |                                     | or Location of Dea       |                                       | 4c. County of Dea                  | ath                          |
| Funera   | al l             |  | Sex 7. Age  | e (In yrs. last birthd | Elkton<br>ay) If Under 1 Ye         | ear If Under 24H         | rs. 8. Date of Birt                   | Cecil th(MM/DD/YYYY) 9. E          | Birthplace (State or         |
| Directo  |                  | 213-80-9409 1 Usual Residence of Decedent  | <b>X</b> M 2 F  | 46                     | Yrs. Months Da                      |                          | in.                                   | Fore                               | eign<br>Country) PA          |
| w any  |                  | 10a. State 10b. County   |   | 10c. City, Town or     | Location                            |                          |                                       |                                    | 10d. Inside City Limits      |
| Maryland 28a-f show a  | į                | MD Ce  | cil   | E1                     | kton                                |                          | 1.22                                  | 0                                  | 1 Yes 2 X No                 |
| he Mar<br>or 289   | Director         | 120 Johnsto  | n Pd  |                        | 10f. Zip Code                       | 21921                    | 110                                   | Og. Citizen of What Co             | ountry?                      |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f shouling of other treatments of the Market of the Termina materials. | eral             | 11. Marital Status   | 12. Was Decedent  | Ever in U.S. 1         | 3. Was Decedent of H                | lispanic Origin? (       | Specify Yes or No-                    | 14. Race - Am                      | erican Indian, Black,        |
| er death   | Funeral          | 1 Never Married 2 Marri 3 Widowed 4 😿 Divorce  | 1 Yes 2   | X No                   | If Yes, specify Cuba                |                          | to Rican, etc.)                       | White, etc.                        |                              |
| ours aft   | d b              | 45 5 4 5 5 5 5 5 5   | ed If Yes, Give Year<br>or Dates:<br>only highest grade com | pleted) 16a. De        | 1 Yes 2 X N cedent's Usual Occup.   | ation (Give kind of      |                                       | Specify: W                         |                              |
| 36<br>n 72 hc  | Completed        | Elementary/Secondary (0-12)  | College (1-4 or 5   | +)                     | ring most of working lif            | e. DO NOT use re         | etired)                               |                                    |                              |
| 215-0036 be filed within 7 tal Hygiene. Hed other than the Moti  | Į Ę              | 11<br>17. Father's Name (First, Middle, La   | st)   | C                      | arpenter                            | 18.Mother's Nam          | ne (First, Middle, M                  | Constru                            | action                       |
| 1215<br>  De file<br>ental Hy<br>  rrked o   | Be               | Harold P. W  | alls  |                        |                                     | Esth                     | er M. ]                               | Dill                               |                              |
| MD 21;<br>id 2 should builth and Men<br>m 27 is mar  | ဥ                | 19a. Informant's Name/Relationship  Donna Huffma   |   | 7.0                    | Mailing Address (Stre               |                          |                                       |                                    |                              |
| e, M<br>l and 2<br>Health<br>item 2  |                  | 20a. Method of Disposition   |   | 20b. Place of D        | 20 Johns<br>Disposition (Name of co |                          | Date Date                             | 20c. Location - City of            | 2 1 9 2 1<br>or Town, State  |
| MOF<br>Pages<br>lent of<br>int: If   |                  | 1 X Burial 2 Cremation 3 4 Donation 5 Other Spec   |   |                        | or other place) n Manor             |                          | gust<br>2007                          | E1kton,                            | , MD                         |
| Baltimore,<br>permit. Pages I ar<br>Department of Hes<br>Important: If ite   | ,                | 21. Si materi vin rel Service Lic  |   |                        | 22. Name and Addres                 | ss of Facility           |                                       | Home                               |                              |
| Physicia   |                  | 23a. Part I. Enter the disease, or cor   | mplications that caused t                                   | he death. Do not e     |                                     |                          |                                       |                                    | 2 1 0 2 1<br>te Interval     |
| /Medica  |                  | failure. List only one cause on  | each line.<br>a. Hypertensiv                                |                        |                                     |                          |                                       |                                    | Between Onset and<br>Death   |
| Examine  |                  | or condition resulting in death)   | Due to (or as a consec                                      | quence of): hyp        | erthermia                           |                          |                                       | *                                  |                              |
|  | ner              | Sequentially list conditions,<br>if any, leading to immediate<br>cause. Enter Underlying Cause | b   | quence of):            |                                     |                          |                                       |                                    |                              |
|  | Examiner         | (Disease or injury that initiated events resulting in death) Last                              | c.<br>Due to (or as a conse                                 | quence of):            |                                     |                          |                                       |                                    |                              |
| 760, Treate be executed a physician and the burial - transit   | i<br>E           |  | d   |                        |                                     |                          |                                       |                                    |                              |
| 60,<br>ate be ex<br>hysician   | Medical          | X UNPENDED  IF FEMALE:   | X AMENDED<br>#1,23a,27                                      | 28a-f, perl            | ME,g870, 8/23                       | 3/07 TT                  |                                       | 23d. Date of delive                |                              |
| OX 687(<br>eath certifica<br>attending ph  | an/N             | 23b. Was decedent pregnant in the past 12 months?  | 1 Live birth  | 2                      | Fetal death 3                       | Ectopic pregr            | ancy                                  | Month Month                        | Day Year                     |
| Box 687 e death certific the attending ped for use as the  | Physician/       | 1 Yes 2 No 9 Unknow  | 4 Pregnant at to 9 Unknown                                  | me of death 5          | Other (Specify)                     |                          |                                       |                                    |                              |
| P.O. I es that the gened by the detaches   | by Ph            | Part II. Other significant condition   | contributing to death                                       | but not resulting in   | the underlying cause                | given in Part I.         |                                       | pacco use contribute to            | -                            |
| 45, Fraguires 1  | ted t            |  |   |                        |                                     |                          | 1 Yes                                 |                                    | obably 4  Unknown            |
| Division of Vital Records, tal or Attending Physician: The taw require is after death. After this certificate has been sided in by the funeral director nace 2 should be din by the funeral director nace 2 should be  | Completed        |  |   | <u> =</u>              |                                     |                          | autops<br>perforr                     | y prior to<br>ned? death?          | completion of cause of       |
| tal Rection: The certificate ector, page   |                  | 25. Was case referred to medical   |   |                        | 26.Plac                             | e of Death (Check        | 1 Yes 2                               | No 1 🗸                             | Yes 2 No                     |
| Vita<br>hysicia<br>this ce   | ا <del>-</del> ا | examiner?<br>1 ✓ Yes 2 No  | Hospital: 1 Inpatien  |                        |                                     | Other Nursi              |                                       | Residence 6 🗸 Oth                  | er: Scene                    |
| n of '<br>Iding Ph<br>h.<br>: After t  |                  | 27. Manner of Death  1 Natural 5 Pending   | 28a. Date of Injury<br>(Month, Day,Ye                       | y 28b. Tim<br>ar)      |                                     | ury at Work?<br>Yes 2 No |                                       | ow injury occurred<br>to high envi | ronmental                    |
| /iSior<br>r Attend<br>ter death<br>irector:  | ficati           | 2 X Accident Investigated Suicide 6 Could not  | ation 8/ // 2007  | ury - At home, farm,   | pm AA                               |                          |                                       | treet and Number or F              | Rural Route Number, City     |
| Divi<br>spital or<br>cours after<br>neral Dir  | Certification:   | 4 Homicide determin  |   | a-Potty @              | junkyard (fou                       | ınd)                     | or Town, Sta<br>320 Red H             | <sup>ate)</sup><br>i11_Rd_Elkto    | on, MD                       |
| Hos<br>74 h<br>Fur<br>telv   | Medical          |  | cian: To the best of my<br>er:On the basis of exam          |                        |                                     |                          |                                       |                                    |                              |
| To the within To the Complex   | Med              | 29b. Signature and title of certifier  | and manner stated.  |                        | 29c. Licen                          |                          | · J v                                 | 29d. Date signed (M                |                              |
|  |                  | 4 m  | 1.1/  |                        | O.C.                                | M.E.                     |                                       | August 8, 2007                     |                              |
| _  |                  | 30. Name and address of person who   | completed cause of de<br>Chief Medical Ex                   |                        | Penn Street, Ba                     | Itimore. MD 2            | 1201                                  |                                    |                              |
|  | state            | 31. Date filed (Month, Day Year)   |   | s Signature            |                                     |                          |                                       |                                    | ····                         |
| Regi   |                  | AUG I 6  | 2007 10000  | e He                   | Proces D                            |                          |                                       |                                    |                              |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene: U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2007 August 12:41 A<sup>M</sup> Charles Moseley 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 20005 Three Notch Road Lexington Park St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 231-44-9839 69 **Director** 04/20/1938 Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Eximpliner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 ☐Yes 27 No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20005 Three Notch Road 20653 Funeral United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1957-59 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Printer Government Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Emory Wall Mary Hazel Lett ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy K. Wall/Wife 20005 Three Notch Rd. Lexington Park, MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 08/07/2007 Charlotte Hall, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Kyle S. Simons M01206 22955 Hollywood Rd. Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Colon **Physician** Metastah /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) Physician/Medical as attending properties of 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 21210 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 25 No 1∐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ed by the a To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica nin 24 hours after death.
the Funeral Director: After th
npletely filled in by the funeral

Baltimore, Maryland 21215-0036

State Registrar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

Hollywood, mo 20036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

hree Notch Rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day 2007 Month **Physician** August 4, 220 A Robert Wesley Whitacre /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 339 Joe Whitacre Road 0akland Garrett 8. Date of Birth (Month, Day, Year)
Mar. 30, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1**X**M 2□F Months Days Hours Yrs. 1934 Maryland 213-34-4285 73 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10c. City. Town or Location 10b. County 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Garrett 0akland 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? ò 21550 USA 339 Joe Whitacre Road tems 23s death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mentel Hygiene important: if item 27 is marked other than "natural; or Item any injury or other traumatic avent, the Medical Exempted PARE. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Town Street Dept. 11 Laborer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Janet Sines Whitacre Evelyn Joseph 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 339 Joe Whitacre Road, Oakland, Maryland 21550 Robin E. Werstein/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/8/07 Morgantown, WV Omega Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility 32 S. Second St. Oakland, MD 21550 Stewart Funeral Home Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Lung Cancer Months /Medical Due to (or as a consequence of) **Examiner** Years COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attanding Physician: The law requires that the death certificate be executed ete hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did lobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus, type II 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔀 No within 24 hours aftar death. To the Funeral Director: After this certifice completely filled in by the funeral director, i 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 AResidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 X Natural 5 Pending м 1 Tes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospitel 29a. Certifier 1XX Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H26154 8/6/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Dr. P. Daniel Miller, DO

2007

31. Date filed (Month, Day, Year)

32 Registrar's Signature

69 Wolf Acres Road, Oakland, Maryland

10f. Zip Code

1 ☐ Yes 2 🛣 No

Health Aide

16a. Decedent's Usual Occupation

20743

(Give kind of work done during most of working life. DO NOT use retired)

4b. City, Town, or Location of Death

Seat Pleasant If Under 1 Year | If Under 24 Hrs. Months Days Hours Min.

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

July

8. Date of Birth (Month, Day, Oct. 29

18. Mother's Name (First, Middle, Maiden Surname) Margaret Hayward

Oct.

Williams

10c. City, Town or Location

Seat Pleasant

7. Age (In yrs. last birthday)

66

Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 █**\**No If Yes, Give Year or Dates:

College (1-4or 5+)

Mae

1 □ M 2X F

Prince George's

15. Decedent's Education (Specify only highest grade completed)

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 No

South Carolina

4c. County of Death

10g. Citizen of What Country?

16b. Kind of Business/Industry

Private

U.S.A.

1940

Prince George's

14. Race - American Indian,

**Black** 

Black, White, etc

8:40 A M

Director 28a-f show "natural", or items 23a or 28a-f sh edical Examiner must be notified filed within 72 hours after death Baltimore, Maryland 21215-0036 the Medical al Hygiene. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once.

**Physician** 

/Medical

Examiner

**Funeral** 

Annie

Social Security Number

10a. State

Director

Funeral

þ

Completed

Md

11. Marital Status

10e. Street and Number

252-60-0305

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

69th Street

10b. County

203 69th Street

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Richard B. Hamilton

12th

Physician /Medical Examiner

The law requires that the death certificate be executed burial-1 physician as the attending p for use as ned by the a sign be peen page ; certificate or Attending Physician: this funeral After ours after death.
neral Director: A
filled in by the fu

Box 68760.

P.O.

Division or Vital Records,

19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 69th Street Seat Pleasant, Maryland 20743 James Williams/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/3/2007 Suitland, Maryland Lincoln Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Foreral Service Licensee 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcinoma, Breast, Bilateral years Metastatic Breast Cancer, Local Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): And Lymph Nodes Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 Ves 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 2X No 3 Probably 4 Unknown Exogenous Obesity 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? res 2 No 1☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 5√ Residence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of Contifier 29c. License number 29d. Date signed (Month, Day, Year) July 31, 2007 D20824 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glenn Jaucian M.D. 9450 Pennsylvania Avenue # 18 Upper Marlboro, Maryland 20772 31. Date filed (Month, Day 32. Registrar's Signa State AUG 0 1 2007 Registrar

DHMH 17 Rev 1/2001

within 24 hours a

completely

|  |   |                   | Please   | Type or Print in E<br>State of Marylan  |                                 |   |   | -                                     |                        | _  |   |
|--|---|-------------------|--|---|---------------------------------|---|---|---------------------------------------|------------------------|--|---|
|  |   |                   | For<br>State<br>Registr <i>a</i> r   | State of Marylan  | •                               | rtificate of                                |   |                                       | Reg. No.               | 0.7  | 2511.9  |
|  |   |                   | Registrar     Decedent's Name (First, Middle, Last   | et)   | 00.                             | Timoato or                                  | Douth                                     | 2. Date of Dea                        |                        | 001  | 3. Time of Death                              |
|  | Physici   | an                | CHARLES OLIVER   | WISE  |                                 |   |   | AUGUST                                | Day                    |  | 3:00A.M.                                      |
| A SECTION AND ADDRESS OF THE PARTY OF THE PA | /Medic  |                   | 4a. Facility Name (If not institution, give  |   |                                 | 4b. City, Town, o                           | or Location of Death                      |                                       |                        | County of Death                                    | 3:00A.M.                                      |
| <i>Ř</i><br>3 –  | Examin  |                   | REEDERS MEMORIAL  5. Social Security Number 6. S   | HOME  | last hirthdav)                  |   | OONSBORO                                  | 8. Date of Birth                      | 1                      | WASHIN<br>9. Birth                                 | GTON place (State or Foreign                  |
| 400  | Funeral<br>Director   |                   |  | MM 2□F 99   | Yrs.                            | Months Days                                 | Hours Min.                                | JAN. 27                               | , Year)<br>, 19        | 08 M   | ARYLAND                                       |
|  | filed within 72 hours after death with the Maryland<br>Hygiene.<br>ther than "natural", or items 23a or 28a-f show<br>ther, the Medical Examiner must be notitled at  | ctor              | 10a. State 10b. County  MARYLAND WASHI   |   | y, Town or Lo                   | ocation                                     | FAIRPLAY                                  |                                       |                        |  | 10d. Inside City Limits 1 ☐ Yes 2 ☒ No        |
|  | th the  | Director          | 10e. Street and Number   |   |                                 | 10f. Zip Code                               |   | 1                                     | 10g. Citi:             | zen of What Cou                                    | ntry?   |
|  | th wii  |                   | 18146 LAPPANS RO   | AD  |                                 |   | 21733                                     |                                       |                        | U.S.   |   |
|  | r dea   | Funeral           | 11. Marital Status   | 12. Was Decedent Ever in U.<br>Armed Forces?  | S. 13.                          | Was Decedent of H<br>If Yes, specify Cub    | Hispanic Origin? (S<br>an, Mexican, Puert | pecify Yes or No-<br>o Rican, etc.)   |                        | <ol> <li>Race - Ameri<br/>Black, White,</li> </ol> |   |
| Maryland 21215-0036  | s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notitled at | by                | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:  |                                 | 1 ☐ Yes 2 🙀 No                              | _   |                                       |                        | Specify:   | WHITE   |
| 5-(  | "natı   | Completed         | 15. Decedent's Ec<br>(Specify only highest gra   |   | 16a. Dece<br>(Give              | dent's Usual Occup kind of work done        | pation<br>during most of wor<br>d)        | king                                  | 160. KII               | nd of Business/Ir                                  | idustry                                       |
| 121  | within<br>ene.<br>than  | ш                 | Elementary/Secondary (0-12)  | College (1-4or 5+)  | <i></i>                         | FARMER                                      | ω,  |                                       |                        | FARMING  |   |
| d 2  | filed withi<br>Hygiene.<br><b>other tha</b> n   |                   | 17. Father's Name (First, Middle, Last,  | )   |                                 | TARCHAR                                     | 18. Mother's Nan                          | ne (First, Middle,                    | Maiden                 |  |   |
| au   | ould be and Mental arked o  | To Be             | OLIVER MILTON WIS  | E   |                                 |   | IRESTA M                                  | IAE HAUPT                             | 2                      |  |   |
| ary  | 2 should and Men Is marke   |                   | 19a. Informant's Name/Relationship (   | Type. Print)  | 19b. Maili                      | ng Address (Street                          | and Number or Ru                          | ıral Route Numbe                      | r, City o              | r Town, State, Zi                                  | o Code)                                       |
| _  | 1 and 2.<br>Health a<br>tem 27 is   |                   | LINDA MILLER/GRAN  | DDAUGHTER   | 1814                            | 6 LAPPAN                                    | S ROAD, F                                 | 'AIRPLAY,                             | MAl                    | RYLAND   | 21733   |
| altimore,  | of He of He item  |                   | 20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐  |   | lace of Dispo<br>emetery, cre   | osition (Name of<br>matory or other pla     | ce)                                       | Date                                  | 20c. Lo                | cation - City or T                                 | own, State                                    |
| <u>Ξ</u> ,   | Pages<br>nent of P<br>ant: If ite<br>ury or o   |                   | 4 □ Dopation 5 □ Other (Specific   |   | NEVOLA                          | CEMETERY                                    | 8/09                                      | /2007                                 | BOOM                   | NSBORO,  | MARYLAND                                      |
| Balt   | permit. Pages 1 a Department of Hez Important: If item any Injury or othe   |                   | 21. Signature of Functial Service Licer  | Paul M. De  |                                 | 2. Name and Addre                           |   |                                       |                        | ational<br>Marylan                                 |   |
| Ass.   | Physician   |                   | 23a. Partt. Enter the disease, or earn<br>shock, or heart failure. List only<br>Immediate Cause (Final | DA 2 2 - 01   |                                 | ter the mode of dyi                         |   | or respiratory and                    | rest,                  |  | Approximate Interval Between Onset and Death  |
|  | /Medical  |                   | disease or condition resulting in death)   | Due to (or as a conseq  |                                 | - Corr                                      |   |                                       |                        |  |   |
|  | Examiner  |                   | Sequentially list conditions,  | b. CACIHE   | XIA                             |   |   |                                       |                        |  | 3monin.                                       |
|  | p #   | iner              | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                          | Due to (or as a conseq  | uence of):                      |   |   |                                       |                        |  |   |
|  | executed<br>in and<br>ial-transit   | Examin            | that initiated events resulting in death) Last   | c   | uence of):                      |   |   |                                       |                        |  |   |
| 60,  |   |                   |  | Dac to (or as a conseq  | 201100 01).                     |   |   |                                       |                        |  |   |
| 9289   | physicate sthe  | dic               |  | -d  |                                 |   |   |                                       |                        |  |   |
| Box  | The law requires that the death certificate be<br>ate has been signed by the attending physicis<br>bage 2 should be detached for use as the bur   | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                | 23c. If yes, outcome pf pregna<br>1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of d<br>9 ☐ Unknown | ideath 3[                       | ⊒Ectopic pregnand<br>☐ Other (specify) _    | sy  |                                       | 1                      | 23d. Date of deliv<br>Month                        | rery<br>Day Year                              |
| P.O.   | uires that the de<br>signed by the a<br>Id be detached t  |                   | Part II. Other significant conditions  | contributing to death but not res   | ulting in the u                 | ınderlying cause gi                         | ven in Part I.                            | 23e. Did to                           | bacco u                | ise contribute to                                  | the cause of death?                           |
| ds   | uires<br>sign<br>ld be  | d by              |  |   |                                 |   |   | 1 🗆 Y                                 | es 2[                  | □ No 3□ Pro  | bably 4 Unknown                               |
| or Vital Records,  | e law requir<br>has been si<br>e 2 should l   | Completed         |  |   |                                 |   |   | 24a. Was a<br>autop                   |                        | 24b. Were aut<br>prior to co<br>death?             | opsy findings available ompletion of cause of |
| al F   |   |                   |  |   |                                 |   |   | 1 Yes                                 | 2 No                   |  | 2 □ No  |
| Vit  | Physiclan:<br>this certificaral director, p   | Be                | 25. Was case referred to medical examiner?   | Hospital:   | EB/Outpotio                     | nt 3□ DOA Ott                               | hor:                                      | ath (Check only or                    |                        | C Dother (Cook                                     | 16.4  |
| ō  | Phys<br>r this<br>ral di  | : To              | 1 Yes 2 No<br>27. Manner of Death  | 28a. Date of Injury   | ER/Outpatie<br>28b. Time of     |   |   | lome 5 ☐ Resid                        |                        |  | ny)   |
| on   | ding<br>h.<br>Afte<br>fune  | tion              | 1 Natural 5 Pending 2 Accident investigation   | (Month, Day Year)   | Injury                          |   | irk?<br>]Yes 2∐No                         |                                       |                        |  |   |
| Division   | l or Attending<br>after death,<br>Director: After<br>I in by the funer  | Certification:    | 3 Suicide 6 Could not b<br>4 Homicide determined   | e 28e. Place of injury - At he building, etc. (Special  | ome, farm, st                   | reet, factory, office                       |   | 28f. Location (S<br>City or Tow       | Street an<br>vn, State | d Number or Rui                                    | al Route Number,                              |
| _  | To the Hospital or Attending Ph within 24 hours after death, To the Funeral Director: After th completely filled in by the funeral  | ledical Co        | 29a. Certifier (Check only one) 1 Certifying Ph  | nysician: To the best of my kno<br>miner: On the basis of examina<br>and manner stated.               | owledge, dea<br>ation and/or in | th occurred at the t<br>nvestigation, in my | ime, date and place<br>opinion, death occ | e, and due to the curred at the time, | cause(s)<br>date and   | ) and manner as<br>d place, and due                | stated.<br>to the cause(s)                    |
|  | To the within To the Somple   | Me                | 29b. Signature and title of certifier  |   |                                 | 29c. Licen                                  | se number                                 |                                       | 29d. Dat               | te signed (Month                                   | , Day, Year)                                  |
|  | . 71-0  |                   | > Thede  | MO  |                                 | ) Di  | 46561                                     |                                       | Am                     | 9.06   | 2007  |
|  |   |                   | 30. Name and address of person who   |   |                                 |   | ,   |                                       |                        | 1,   |   |
| h  | H-6   |                   | DD CHAZALA OADI  | D 20311 ΙΔΡΡΙ   | INS PO                          | AD ROOMS                                    | BORO MA                                   | RYLAND 2                              | 1713                   | 301-   | 432-8470                                      |

State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 0 1 2007

Dennis DeShields MD 219 S. Washington St., Easton, Md.

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No... 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 28 2007 3:03PM M JULY YALDAH LOUISE WHITBY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CAROLINE DENTON RUXTON HEALTH CARE OF DENTON 8. Date of Birth (Month, Day, Year) MAY 13, 1916 If Under 24 Hrs. Hours Min. If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs 1 ☐ M 2 😿 F MARYLAND 91 216-80-2828 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 NO r 28a-f sh notified Director **EASTON** TALBOT MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 29469 RABBITT HILL ROAD 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes X No Specify Baltimore, Maryland 21215-0036 Specify: þ WHITE 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Flementary/Secondary (0-12) OWN HOME HOMEMAKER 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be th and Mental F 7 is marked of traumatic ever LEONA AUGUSTUS WHITE CLARENCE D. CHANCE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Health em 27 i CAROLYN F. DADDS/DAUGHTER 29469 RABBITT HILL ROAD, EASTON, MARYLAND 21601 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of H ant: If Ite ury or otl 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) WHITEMARSH CEMETERY 8/2/2007 TRAPPE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA CHOL MERCERON 200 S. HARRISON ST., EASTON, MD 21601 R. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) failure **Physician** Renal /Medical Due to (or as a consequence of): Examiner advanced dementio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): physician al s the burial-t Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 ☐ Yes 2 ☐ 48 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 № 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes page 2 has certificate 1□ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tes P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending Natural 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 h (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

5+2

31. Date filed (Month, Pay 2007 0

Melind

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

wher

Led rum Ave Preston MD 136 strar's Signature 32. Re

MD

Registrar DHMH 17 Rev 1/2001

State

00053255

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 30 2007 0756 AM JOHN R. WISMER JUI 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Easton Talbot Memorial Hospital at Easton If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JAN 19,1917 9. Birthplace (State or Foreign 5. Social Security Number Months Days Hours Min. 90 MN 381-03-1492 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 XNo TALBOT TRAPPE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21673 USA 4376 BAILDON ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WATCH MANUFACTURING MANUFACTURERS REP. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LILLIAN OPSTAD KARL R. WISMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LOLA L. WISMER/WIFE 4376 BAILDON ROAD, TRAPPE, MD 21673 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State ARLINGTON NATIONAL CEM. 9/20/2007 ARLINGTON, VA 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 Joseph 711. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arrhathmia minules Due to (or a a consequence of 14 Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Huge-tension Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tohacco use contribute to the cause of death? alestoolemia 2 □ No 3 Probably 4 ∏Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day Year)

**Physician** /Medical Examiner Examiner The law requires that the death certificate be executed

the attending physician

Physician

/Medical

Examiner

MD

Funeral

þ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.

Baltimore, Maryland 21215-0036

death with the Maryland

burlal-tran use as t n signed by the Id be detache funeral director,

Physician/Medical

ģ

Completed

Be

Medical Certification: To

Division or Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

After this

within 24 hours after death To the Funeral Director:

10 + VA

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

1 ☐ Yes 27. Manner of Death

5 ☐ Pending investigation

6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

3 Suicide

4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

AUG

29c. License number D42816

Laston

29d. Date signed (Month, Day, Year) 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI

Suracune 31. Date filed (Month, Day, Year)

200 0

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day WILLIAMSON 6 2007 /Medical 5:39 4a. Eacility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONA Medical SALISBURY (Ni comico eninsu/a Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 1 F Days Hours Min. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director HEBRON KICOMICO 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r ATHOL 2183C 1 and 2 should be filed within 72 hours after death 1 Health and Mental Hygiene. Mar Z is marked other than "natural", or Items 23, ther traumatic event, the Medical Examiner must Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 00 Specify: WHITE 1 ☐ Yes 2 ☐ No Specify ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWNED HOME 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last, EDITH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1800 ATHOLIND HEBRON MD 21830 GRANVILLE WILLIAMSON HUSBARR Department of Health Important: If item 27 any injury or other troonce. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 7-31-2007 4 □ Donation 5 □ Other (Specify) TYASKIN, MID 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CL HOME 23a. Part 1. Firer the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of) Examiner potensio Sequentially list conditions, if any, the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician and deedeched for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autops 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 □ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? (Month, Day Year) 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Division or Vital Records,

peen

certificate

After this

P.O. Box 68760

Maryland 21215-0036

Prospital or Attending Prospital or Attending Prospital Structure Funeral Director: After to the structure of the structure o within 24 hours a

To the Funeral L 6mg

State Registrar

29b. Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

26

29d. Date signed (Month, Day, Year)

Piyush Mehtamo Daive Salisbuny 21804 afenn

29c. License number

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

|   |  |                 | T = For State Registrar   |   | aryland                             |   | artment of F<br>tificate of                                   | lealth and I<br>Death                                 |                                    | Reg. No.                             |   |
|---|--|-----------------|---|---|-------------------------------------|---|---|---|------------------------------------|--------------------------------------|---|
|   | Physici<br>/Medi   |                 | Decedent's Name (First, Mid     ALAN ZABELL   |   |                                     |   |   | or Location of Death                                  | 2. Date of D<br>Month<br>AUGUST    | Day 200                              | 7 3. Time of Death 5:18 A M   |
|   | Examir   | ier             |   | a. Facility Name (If not institution, give street and number)   |                                     |   |   |   | ٦                                  | 4c. County                           |   |
|   |  | ,               | 7919 LAKENHEAT  5. Social Security Number   |   | ge (In yrs. la                      | ant hirthdox                            | POTOMAC  If Under 1 Year                                      | If Under 24 Hrs.                                      | 0 D-4(D)                           | MONTGO                               |   |
|   | Funeral<br>Director  |                 | 096-34-6803   | 1. X M 2 ☐ F  | 61                                  | Yrs.                                    | Months Days   | Hours Min.  | 8. Date of Bi                      | ay, Year)                            | Birthplace (State or Foreign Country)   |
| 4   |  |                 | Usual Residence of Decedent   |   |                                     |   |   |   | APKIL                              | 7, 1946                              | NEW YORK  |
|   | how at   |                 | 10a. State 10b. Coun  | •   |                                     | , Town or Lo                            |   |   |                                    |                                      | 10d. Inside City Limits   |
|   | a-fs   | ctor            | MARYLAND   MONTO  | GOMERY  |                                     | POTOMA                                  | rC  |   |                                    |                                      | 1X Yes 2 No   |
|   | th with th<br>23a or 28<br>ist be no   | al Director     | 10e. Street and Number 7919 LAKENHEATH  | H WAY   |                                     |   | 10f. Zip Code   | 20854   |                                    | 10g. Citizen of V                    | Vhat Country?<br>USA  |
| 2-0036  | n /2 nours after death with the Maryland<br>"natural", or items 23a or 28a-f show<br>sdical Examiner must be notified at   | by Funeral      | 11. Marital Status 1 □ Never Married 2 ☑ Ma 3 □ Widowed 4 □ Divorce   | If Ves Give   | ,                                   |   | Vas Decedent of H<br>f Yes, specify Cub                       | lispanic Origin? (S<br>an, Mexican, Puert<br>Specify: | pecify Yes or No<br>o Rican, etc.) | o- 14. Rac<br>Blac<br>Specify        | e - American Indian,<br>k, White, etc.<br>:: WHITE                                |
| င်  | d within 72 ho<br>giene.<br>Ir than "natur<br>the Medical I  | Completed       | 15. Decede<br>(Specify only high<br>Elementary/Secondary (0-12)   | ent's Education<br>nest grade completed)  College (1-4or  | 5+)                                 | (Give .                                 | lent's Usual Occup<br>kind of work done<br>DO NOT use retired | during most of wor                                    | king                               | 16b. Kind of Bu                      | usiness/Industry  |
| 7   | ygiene<br>/giene<br>erth:  | E O             | Ziomonary, cocondary (o 12)   | 5+  |                                     | P                                       | HYSICIAN  |   |                                    | MED                                  | ICAL  |
| yland   | Mental Hy<br>Mental Hy<br>arked oth  | æ               | 17. Father's Name (First, Middle MAX ZABELL   | e, Last)  |                                     |   |   | 18. Mother's Nan                                      |                                    | e, Maiden Surnam<br>L'Z              | ne)   |
| ≥ .   | permit. Pages I and 2 should<br>Department of Health and Mei<br>Important: If item 27 is marke<br>any injury or other traumatic<br>once.   |                 | 19a. Informant's Name/Relation JUDY ZABELL/WIE  |   |                                     | 19b. Mailin<br>7919                     | g Address <i>(Street</i><br>LAKENHEA                          | and Number or Ru<br>TH WAY,                           | ral Route Numb<br>POTOMAC          | per, City or Town, MARYLA            | State, Zip Code)<br>ND 20854  |
|   | rages la<br>nent of Hea<br>int: If item<br>iry or othe   |                 | 20a. Method of Disposition<br>1X Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (   | a 3 □Removal from State (Specify)   | JUD                                 | ace of Dispos<br>metery, cren<br>EAN ME | sition (Name of<br>natory or other place<br>MORIAL G          | DNS 08/1  | Date 4/2007                        | OLNEY,                               | City or Town, State   |
|   | permit. Fages Department of Important: If i any injury or once.  |                 | 21. Signature of Auneral Service  | e Licensee  |                                     | DA<br>11                                | Name and Addre  | ss of Facility GOLDBERG                               | MEMORIA                            | AL CHAPEI                            | LS, INC.<br>ARYLAND 20852   |
|   | hysician<br>/Medical<br>Examiner   | er              | 23a. Part1. Enter the is ase, shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate | a. Response of complications that caused stonly one cause on each limit a. Due to (or as b. Due to (or as Due to (or as | a conseque<br>Sta                   | Do not ente                             | er the mode of dyir   | ng, such as cardiac                                   | or respiratory a                   | arrest,                              | Approximate Interval Between Onset and Death WEEKS                                |
| 00100   | s a  | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                              | cDue to (or as  | a conseque                          | ence of):                               |   |   | -44                                |                                      |   |
| o the Hospital or Attending Divisions. The low requires that the close of the | requires tractified to talk the stending phenology by the attending by should be detached for use as the   | Physician/Med   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown   | 23c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant a<br>9 ☐ Unknown   | 2 Fetal                             | death 3                                 | Ectopic pregnancy<br>Other (specify)                          |   |                                    | 23d. Dat                             | e of delivery<br>nth Day Year   |
| Olds, F   | en signed b  | þ               | Part II. Other significant condit   | tions contributing to death b   | ut not result                       | ting in the un                          | derlying cause giv  | en in Part I.   | 23e. Did t                         | i./                                  | ibute to the cause of death? 3 ☐ Probably 4 ☐ Unknown                             |
|   | is certificate has be<br>director, page 2 sho  | Completed       |   |   |                                     |   |   |   | 24a. Was<br>auto<br>perfo          | psy prmęd? d                         | Vere autopsy findings available rior to completion of cause of eath?  □ Yes 2□ No |
| VIC   | sertifii<br>ector,   | Be              | 25. Was case referred to medic examiner?  |   |                                     |   | 1   | 26. Place of Dea                                      |                                    | ~-                                   |   |
| 5 8   | this aldir   | ှင              | 1 Yes 2 No  | Hospital: 1 ☐ Inpatie   |                                     | R/Outpatient                            |   | 4 LI Nursing H  |                                    | dence 6 □Othe                        | 1.1.27  |
| ing   | After<br>funer   | Ö               | 27. Manner of Death  Natural 5 ☐ Pendi  | 28a. Date of Inju<br>ing (Month, Da   |                                     | 28b. Time of<br>Injury                  | 28c. Injur<br>Worl  |   | 28d. Describe                      | how injury occurre                   | ed  |
| or Attend   | after death.  Director: After th  in by the funeral  | Certification:  | 3 Suicide 6 Could   | I not be<br>mined 28e. Place of inju-<br>building, et   | ury - At hom<br>c. <i>(Specify)</i> | ne, farm, stre                          |   | Yes 2 □ No  | 28f. Location (<br>City or To      | Street and Number                    | er or Rural Route Number,   |
| A Hoenital  | within 24 hours after death.  To the Funeral Director: completely filled in by the funeral properties of the funeral prope | Medical Ce      | 29a. Certifier (Check only one)  1 Certify 2 Medica   | ing Physician: To the best<br>I Examiner: On the basis of<br>and manner sta   | f examinatio                        | ledge, death<br>on and/or inv           | occurred at the tin<br>estigation, in my o                    | ne, date and place<br>pinion, death occu              | and due to the                     | cause(s) and ma<br>date and place, a | nner as stated.<br>and due to the cause(s)  |
| To the  | within<br>To the   | Me              | 29b. Signature and title of certific  |   | <u></u>                             | 100 1-                                  | 29c. License  | number  |                                    | 29d. Date signed                     | (Month, Day, Year)  |
|   |  |                 | > Kelly   | VIII  | ,                                   | mb                                      |   | D0064115  |                                    | AUG                                  | 13, 2007  |
|   | ا ر  | r               | 30. Name and address of person  | who completed cause of d  | eath (Item 2                        | 23a) (Tyne F                            | Print)  |   |                                    |                                      |   |

State Registrar

DR. KELLY W. MERCER, 9707 MEDICAL CENTER DRIVE, SUITE 300, ROCKVILLE, MD 20850 31. Date filed (Month, Day, Year) **AUG 1** 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 07,2007 Michael J. Alois /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5. Social Security Number Health Core Point If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) Nov 10, 1943 **Funeral** Days Hours Months 1 X M 2 □ F 63 Director 100-34-9051 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2√☐ No E1kton MD Cecil Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 100 Laurel Drive 21921 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 11 Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: white **'**86-91 ģ permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", can yi injury or other traumaticevent, the Medical Example. 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 College (1-4or 5+) Elementary/Secondary (0-12) teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Mullen Joseph Alois 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21921 Bldg 361 Perry Point, MD Perry Point VA Med Ctr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows or heart failure. List only one cause on each line.

Immediate Cluse (Final disease or condition resulting in death) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death Unknown **Physician** /Medical Examiner Se prentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown sate has been signed by page 2 should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? Manner of Death 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide filled in

or Attending Physician: The law requires that the death certificate be executed after death within 24 hours

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

(Check only one) 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

VA Maryland 31. Date filed (Month, Day,

ORIGINAL

State Registra

completely

32. Registrar's Signature answer 15 porte

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vaar **Physician** Ash Wilbert 12 2007 AUGUST /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MA Union Memorial Park Baltimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 10-27-1963 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 5. Social Security Number **Funeral** Days Hours 1**反**M 2□ F 217-84-6099 43 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Md. Baltimore NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21205 829 N. Montford Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Authority nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Baltimore City Housing 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Mitchell Geraldine Ash Bousie 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 Forrest St., Baltimore, Md. 21202 Geraldine Ash Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Mem. Pk. 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot □ Burial 2 □ Cremation 3 □ Removal from State 8-17-07 Randallstown, Md. 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F.H. Fast once. lady 1101 E. North Ave.; Baltimore, Md. 21202 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner that the death certificate be executed the burial-tran attending physiclan and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: . If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the attent detached for u 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Donknown 2 No page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1☐ Yes Attending Physician: ector. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Impatient 2 ER/Outpatient 3 DOA e Hospital or Attending Phys 24 hours after death. e Funeral Director: After this letely filled in by the funeral di 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral Completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) AT 243 8946 18 AUGUST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIYAM, UNION MEMORIAL HOSPITAL, MO
3. Registrar's Signature AMIRA MOHAMMEN 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Registrar

Galtinue

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Antelman MO

Robert W. Ant.
31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 09:55 a.M Physician 2007 Mugust ROSALEE ALDRIDGE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Secur 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 ☐ M 2 🗓 F 219-50-2067 SOUTH CAROLINA 59 12-20-1947 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 28a-f show aţ 1X Yes 2 □ No ral", or items 23a or 28a-f sl Ex miner must be notified Director BALTIMORE N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 21229 USA 64 S. MORLEY ST. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☐ No Specify: BLACK Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 'natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the HOSPITAL NURSING ASSISTANT -11-Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ODESSA GIBBS LEVI SMITH ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 64 S. MORLEY ST. BALTIMORE, MARYLAND 21229 nt of Health a : If item 27 Is TINESTTA ALDRIDGE-YOUNG (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition, 1 □XBurial 2 □ Cremation Department o Important: If i any Injury or once. ARBUTUS MEMORIAL PARK 8-18-2007 BALTIMORE, MARYLAND 4 □ Donation 5 □ Other (Specify) .HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. vice Licensee JONANHAN 21. Signature of Funeta KBn 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enjecthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of bart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Approximate Interval Between Onset and Death hour Physician /Medical Due to (or as a consequence of): inknown Examiner abscess Ung Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examiner non small CHALLY Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 28d. Describe how injury occurred 27. Manner of Death 1 ☑ Natural 28h. Time of

Hospital or Attending Physician: After this within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Medical Certification: To

2 Accident

3 Suicide

29a Certifier

4 Homicide

5 ☐ Pending investigation

6 Could not be determined

28a. Date of Injury (Month, Day Year)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certilier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D47353 29d. Date signed (Month, Day, Year) 2007 14,

State Registrar

-alux MD NOC 31. Date filed (Month, Day, Year) AUG 1

strar's Signature

900 (aton Avenue

Baltomore, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #4b-c,pen'll, 8, per HI, 870, 8/23/0/ TT State of Maryland /'Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AM **Physician** MA /Medical c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Towson WE KUNTON lanor 8. Date of Birth (Month, Day, 5/16/1935 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number **Funeral** Year) Days Min 082-44-3296 1 M 2 DF amaica Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City Form or Location 10b. County 10a. State or 28e-f show treumetic event. The Medical Examiner must be notified at 1 Pres 2 No altimore Mid Completed by Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2120 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status ☐Yes 2 THO f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No ō Specify: Specify: Black Baltimore, Maryland 21215-0036 3 Widowed 4 ☐ Divorced Year or Dates "netural" 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12cl  $\triangle$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ould be Pages 1 and 2 should be ment of Health and Mentatent: If item 27 Is marked MILLER Wild. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) md 21009 Abingdon Caughter, Deerchase larten e Miltons other Deportment of Healt importent: If item 2 any injury or other once. 20b. Place of Disposition (Name of cometery, cremator) or other p Date 20c. cation - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) nural Sucs 21. Signature of Funeral Service Licensee 5151 Baltimore Matt HIKE ratto, ma 21239 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear vailure. List only one cause on each line. Approximate Interval Between Onset and Death SUDDAGE Immediate Cause (Final ISCHEMIC HEART was **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed Division of Vital Records, Completed by page 2 should be ascular 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 1 Yes Physicien: funeral director, 25. Was case referred to medical 26. Place of Death Check onl one Be examiner? Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2 No Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred Manner of D th 28a. Date of Injury (Month, Day Year) 28b. Time of After Hospitel or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funerel Director: the 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) Name and address of person Bolto MD 6 - Secte DOT 32. Registrar's Signature Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** Black 2:10 AM line 2007 August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Sinci Hospital of Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 1991) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 220-24-709 1□M 2**V**F 9 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner myst be notified at Baltimore 1 Yes 2 No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21207 by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📶 No 21215-0036 Specify. 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. BQ NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) condary (0-12) College (1-4or 5+) omestic 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental 19a. Informant's Name/Relationship Health an altimore. 20c. Location -20a. Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) Baltimore, 2 ☐ Cremation 3 ☐ Removal from State 21. Signatur of Funeral Service Liceosee 21133 Randay lotown, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Inferction /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 dunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 2 No 1□ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1 🗹 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D59062 Hugust 14, 2007 M. D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 2401 W Belvedere Baltimore MA 21215 Chad Hensen 32/Begistrar's Signature 31. Date filed (Month, Day, State Registrar College Service

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

3. Time of Death

10d. Inside City Limits

WHITE

21211

21201

Onset and Death

6 months

10years

29d. Date signed (Month, Day, Year)

1X Yes 2 □ No

| Physician  |
|------------|
| /Medical   |
| Examiner   |
| LAdillilei |

**Funeral** Director

Director

by Funeral

Completed

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"natural", or items 23a or 28a-f show dical Examiner must be notified at s 1 and 2 should be fill f Health and Mental H tem 27 is marked oth

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

68760,

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or Attending

Hospital

Pages nent of h permit. Pages Department of Important: If It any Injury or o

**Physician** /Medical Examiner

Item 27 i

this funeral

Physician/Medical

Completed

Be

Certification: To

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Day Year August 2007 FRANK STEVEN BREWER 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE 8. Date of Birth 1 1 - 0 1 - 1 9 5 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign X M 2□F Days 51 Yrs. MARYLAND 218-60-7630 Usual Residence of Decedent 10c. City, Town or Location 10a. State MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 334 W. 29th STREET 21211 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DRIVER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DANTET. BREWER, SR. ARCADIA ARVEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 334 W. 29th STREET, BALTIMORE, MD BREWER - WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State RIVERDALE CREM. 08-16-07 RIVERDALE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility RONALD TAYLOR II FH Sauken 108 W. NORTH AVE., BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARDIOMYOPATHY Due to (or as a consequence of): RENAL STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) SEPSIS Due to (or as a consequence of): OLYSUBSTANCE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

n 24 hours after death.

le Funeral Director; Af
etely filled in by the fur

completely

within 24

State Registrar

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ATZ438946 FIS

MEMORIAL HOSPITAL

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

|                     |   |                        | 1 - State Registrar   | State of M   |                       | d / Depa              |                          | t of H                  | ealth a           |                   | ental Hyg                        | iene<br><sub>ng. No.</sub> | 17          |   | 62                    |
|---------------------|---|------------------------|---|--|-----------------------|-----------------------|--------------------------|-------------------------|-------------------|-------------------|----------------------------------|----------------------------|-------------|---|-----------------------|
|                     | · ·   |                        | 1. Decedent's Name (First, Middle, La   |  |                       |                       |                          |                         |                   | 2                 | 2. Date of Deat<br>Month         | n<br>Day                   | Year        | 3. Time of I                                | Death                 |
|                     | Physicia<br>/Medic  |                        | Henry Thomas E  | ever   |                       |                       |                          |                         |                   |                   | August                           |                            | 007         | 4:50p                                       | М                     |
|                     | Examin  | _                      | 4a. Fecility Name (If not institution, giv  | e street and number  | )                     |                       | 4b. City,                | Town, or                | Location o        | of Death          |                                  | 4c. County                 |             |   |                       |
|                     |   |                        | Continuum Care At   | Sykesvil   | 1e                    |                       | Syk                      | esvi                    | 111e              |                   |                                  | Carı                       | ro11        |   |                       |
| T                   | Funeral   |                        | 5. Social Security Number 6. S  |  |                       | last birthday)        | If Under<br>Months       |                         | If Under :        | 24 Hrs. 8<br>Min. | B. Date of Birth<br>(Month, Day, | Year)                      | 9. Birth    | place (State or                             | Foreign               |
|                     | Director  |                        | 220-10-7462   | M 2□F 8  | 57                    | Yrs.                  | WOTTE                    | Days                    | T TOBIS           |                   | Oct 8                            | 1919                       | MD          |   |                       |
|                     | pu ,  | 1                      | Usual Residence of Decedent   |  | 100 Cin               | y, Town or Lo         | antin -                  |                         |                   |                   |                                  |                            |             | 10d Inside Cit                              | . I i—ita             |
|                     | anyla<br>shov   | _                      | 10a. State 10b. County 10b. Carroll   |  | Too. City             |                       | esvil                    | lle                     |                   |                   |                                  |                            |             | 10d. Inside Cit<br>1 ☐ Yes                  |                       |
|                     | Ba-f  | Sc                     |   |  |                       | - 7                   |                          |                         |                   |                   |                                  |                            |             |   | - 9A · · · ·          |
|                     | vith ti   | 5                      | 10e. Street and Number 5403 Sykesville  | Road   |                       |                       | 10f. Zip<br>217          |                         |                   |                   | 1                                | og. Citizen of V<br>USA    | Vhat Cou    | ntry?                                       |                       |
|                     | filed within 72 hours after death with the Maryland<br>Hygiene.<br>kther then "natural", or Itema 23a or 28a-f show<br>kther then "natural", or Itema 23a or 28a-f show<br>kther then "cited Examination must be notified at  | Funeral Director       |   |  | . F                   | 0 10                  |                          |                         |                   | -:-0 (0           | 4                                |                            |             | can Indian,                                 |                       |
|                     | er de   | ů                      | 11. Marital Status  | 12. Was Deceden<br>Armed Forces                            | ?                     |                       | Yes, spec                | offy Cuba               | n, Mexican        | , Puerto Ri       | ify Yes or No-<br>ican, etc.)    |                            | k, White,   |   |                       |
| 36                  | rs aft  | Ž.                     | 1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced  | 1 t√Yes 2 ☐<br>If <del>Yes</del> , Give<br>Year or Dates   | WW                    | /II                   | 1 ☐ Yes 2                | 2 <b>X</b> No           | Specify:          |                   |                                  | Specify                    | whi         | ite   |                       |
| Ş                   | tura<br>al E  | Completed by           | 15. Decedent's E  |  |                       | 16a. Dece             | dent's Usua              | al Occupa               | ation             |                   |                                  | 16b. Kind of Bu            | siness/Ir   | ndustry                                     |                       |
| 15                  | n "n  | piet                   | (Specify only highest gra   | ide completed)   | 5.1                   | (Give                 | kind of wor<br>DO NOT us | rk done d<br>se retired | during most<br>') | t of working      | 7                                |                            |             | ,   |                       |
| 212                 | l with<br>liene<br>r tha  | E                      | Elementary/Secondary (0-12)   | College (1-4or<br>2  | D+)                   | corre                 | ection                   | nal d                   | office            | er/Ma             | jor S                            | tate of                    | e MD        |   |                       |
| Ö                   | Hyg<br>othe   | Bec                    | 17. Father's Name (First, Middle, Last  | )  |                       |                       |                          |                         |                   |                   | First, Middle, M                 |                            | Θ)          |   |                       |
| lan                 | lid be<br>enta<br>ked<br>ic ev  | ToB                    | John Henry Beve   | er   |                       |                       |                          |                         | Anna              | Mary              | Carabi                           | ne                         |             |   |                       |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-f show any injury or other traumatic event, the Model Examination must be notified at once. |                        | 19a. Informant's Name/Relationship (  |  |                       |                       |                          |                         |                   |                   | Route Number                     |                            |             |   |                       |
|                     | alth a<br>27 is   |                        | Patricia Dorsey   | (daughter)   | )                     | 5403                  | Sykes                    | svill                   | Le Rd             | ., Sy             | kesvill                          | e, MD                      | 2178        | 34  |                       |
| ē,                  | is 1 a<br>of Hea<br>item<br>othe  |                        | 20a. Method of Disposition  |  | 20b. P                | lace of Dispo         | sition (Nan              | ne of<br>ther place     | e)                | Da                | te                               | 20c. Location -            | City or T   | own, State                                  |                       |
| Ë                   | Page<br>ent c<br>nt: If<br>ry or  |                        | 1 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Special   |  | St.                   | Patri                 | ick Ce                   | emete                   | ery 8             | -18-0             | 7 M                              | it. Sava                   | age,        | MD  |                       |
| Baltimore,          | mit.<br>oorta<br>r inju   |                        | 21. Signature of Funeral Service Lice   | nsee   |                       |                       |                          |                         | 1                 |                   | ht Fune                          | ral Hor                    | ne &        | Chane1                                      |                       |
| ä                   | Per imp   |                        | Dauge Saight  | Herbert  |                       | P.                    | О. Вс                    | ox 19                   | 95 Syl            | naig<br>kesvi     | lle, MI                          | 21784                      | ne a        | Onaper                                      |                       |
|                     | Physician   |                        | 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final                                    | plications that cause<br>one cause on each                 | ed the death<br>line. | h. Do not ent         | er the mod               | e of dying              | g, such as        | cardiac or        | respiratory arre                 | est,                       |             | Approximate<br>Interval Betw<br>Onset and D | veen                  |
|                     | /Medical  |                        | disease or condition<br>resulting in death)   | a. Due to (or a  | s a conseq            | uence of):            |                          |                         |                   | -                 |                                  |                            |             | Tea   | 15                    |
|                     | Examiner  |                        | Comments the ties are distance.   | b  |                       |                       |                          |                         |                   |                   |                                  |                            |             | -   |                       |
|                     | n =   | ner                    | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or a   | s a conseq            | uence of):            |                          |                         |                   |                   |                                  |                            |             |   | -                     |
|                     | te be executed<br>ysician and<br>te burial-transit  | Examiner               | Cause (Disease or injury that initiated events  | c  |                       |                       |                          |                         |                   |                   |                                  |                            |             |   |                       |
| oʻ                  | e exe<br>ian a<br>urial-  | EX                     | resulting in death) Last  | Due to (or a   | s a conseq            | uence of):            |                          |                         |                   |                   |                                  |                            |             |   |                       |
| 3760,               |   | ical                   |   | d  |                       |                       |                          |                         |                   |                   |                                  |                            |             |   |                       |
| 89 )                | The law requires that the death certifica<br>ate has been signed by the attending ph<br>page 2 should be detached for use as th   | Physician/Med          | IF FEMALE:  |  |                       |                       |                          |                         |                   |                   |                                  |                            |             |   |                       |
| Вох                 | ath ce  | an/                    | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcom<br>1 ☐ Live birth                      |                       |                       | ∃Ectopic pr              | egnancy                 |                   |                   |                                  | 23d. Dat<br>Mo             | e of deliv  |   | 'ear                  |
|                     | the a   | Sici                   | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   | 4☐ Pregnant :<br>9☐ Unknown                                | at time of d          | eath 5□               | Other (sp                | ecify)                  |                   |                   |                                  |                            |             | Juy .                                       | ou.                   |
| P.O.                | d by  | F.                     | Part II. Other significant conditions   | antibuting to dooth  | but not son           |                       |                          |                         | an in Dard I      |                   | 230 Did to                       | pacco use conti            | ributo to t | the sauce of de                             | nath?                 |
| Š,                  | signe<br>d be c   | þ                      | Partil. Other significant conditions  | contributing to death                                      | Dat not 195           | aiting in the a       | riderlying C             | ause give               | en in Fan i.      |                   | 1 □ Ye                           | 1                          |             | bably 4 □U                                  |                       |
| Ö                   | w require<br>been si<br>should t  | ted                    | -   |  |                       |                       |                          |                         |                   |                   |                                  | 3 2 7 60                   | 0_1.0       |   |                       |
| Records,            | a faw   | Completed              |   |  |                       |                       |                          |                         |                   |                   | 24a. Was a autops                | у г                        | prior to co | opsy findings a<br>empletion of ca          | ıvailable<br>ıuse of  |
| H                   | The cate l  | Š                      |   |  |                       |                       |                          |                         |                   |                   | perform<br>1 Yes 2               |                            | death?      | 2□ No                                       |                       |
| Vital               | Physician:<br>this certificaral director, a   | Be                     | 25. Was case referred to medical examiner?  | Hannital:  |                       |                       |                          | 0"                      |                   | of Death          | Check only on                    | θ)                         |             |   |                       |
| of                  | this c  | ဥ                      | 1 ☐ Yes 2 🕱 No  | Hospital: 1   Inpai  |                       | ER/Outpatier          |                          | - 1                     | 4 (3144)          |                   | e 5 Reside                       |                            |             | fy)   |                       |
| Ë                   | ing F   | on                     | 27. Manner of Death 1 ☐ Natural 5 ☐ Pending   | 28a. Date of In<br>(Month, D                               | lay Year)             | 28b. Time o<br>Injury |                          | 8c. Injury<br>Work      | <b>κ</b> ?        |                   | ld. Describe ho                  | w injury occurs            | ed          |   |                       |
| Division            | l or Attendi<br>after death.<br>Director: A<br>I in by the fu   | cat                    | 2 Accident investigation 3 Suicide 6 Could not be   |  |                       | ,                     | M                        |                         | Yes 2⊡i           |                   | Y 1 (0)                          |                            |             | -1.0 M                                      |                       |
| Ξ                   | or At<br>fiter of<br>Direction by   | ıı                     | 4 Homicide determined   | 286. Place of I  | etc. (Specif          | ome, tarm, str        | reet, tactory            | , office                |                   | 28                | 3f. Location (St<br>City or Town | reet and Numb<br>i, State) | er or Hur   | ai Houte Numi                               | <i>3</i> ⊖ <i>r</i> , |
|                     | pital<br>urs a<br>erai l  | S                      | Continue de Continue Di   | isisas T. W. L.  | 4 -4 1                |                       | <b>.</b>                 |                         |                   | 1-1               |                                  |                            |             |   |                       |
|                     | To the Hospital or Attending Physician: The taw<br>within 24 hours after death.<br>To the Funeral Director: After this certificate has<br>completely filled in by the funeral director, page 2  | Medical Certification; | 29a. Certifier Certifying Pi<br>(Check only 2 Medicel Exa   | nysicien: To the bes<br>miner: On the basis<br>and manner: | of examina            | tion and/or in        | vestigation,             | , in my of              | pinion, dea       | th occurred       | d at the time, d                 | ate and place,             | and due t   | o the cause(s)                              | ſ                     |
|                     | ithin (   | Mec                    | 29b. Signature and title of certifier   | and manner s   | statou.               | -                     | 290                      | . License               | e number          |                   | 2                                | 9d. Date signe             | d (Mjönth.  | Day, Year)                                  |                       |
|                     | To To Con   |                        | 1771  | 110  |                       |                       |                          | Da                      | 200               | 10-               | .   -                            | 8/17                       | 10-         | 7   |                       |
|                     | . 1   |                        | musq  | (VII)  | don't //-             | - 00e) (T -           | Drint)                   |                         | 1281              | 57                |                                  | 0/1/                       | 1-1         | /   |                       |
| 5                   | γ   |                        | 30. Name and address of person who  | completed cause of   | G C+                  | 1 ZJa) (Type,         | W a                      | C+                      | 20                | 7 /               | restor                           | La cha                     | 1           | 102   | 115-                  |
| 4                   | Sta   | to.                    | 31. Date filed (Month, Day, Year)   | 32. Re <b>cts</b>  | trar's Signa          | iture                 | ITVE                     | 21                      | 20                |                   | cylor                            | 17/1/2                     | 10          |   |                       |
|                     | Registr   |                        |   | 2007   | Bus                   |                       | Granti                   | 0                       |                   |                   |                                  |                            |             |   |                       |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 14 Day 5:01 PM 07 BOHard SCott 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) MD medical center Baltimore, MD N/A university | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 14, 1967 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex MaryTand Feb. 1 X M 2 □ F Yrs 40 234-23-7244 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Frederick Frederick Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21701 6316 Remington Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2K Married 1 ☐ Yes 2 No White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Frederick County Public College (1-4or 5+) Elementary/Secondary (0-12) School System Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joan M. Nethers Larry G. Bolyard, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Frederick, Maryland 21701 6316 Remington Dr. Mrs. Alison Bolyard/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 8/20/07 Parkton, Maryland Bee Tree Cemetery 4 □ Donation 5 □ Other (Specify) Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or implications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List inly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Crohns Due to (or as a consequence of): Necrotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dfic Due to (or as a consequence of): IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy

/Medical **Examiner** requires that the death certificate be execute sician and burial-tran Division or Vital Records, P.O. Box 68760, physician a attending p ed by the a signed by t 1 be detach

**Physician** 

Examiner Physician/Medical Be Completed by page 2 certificate Certification: To this After t lospital or Attendl hours after death. uneral Director: A

**Physician** 

/Medical

Examiner

Director

Funeral

2

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evandor.

Baltimore, Maryland 21215-0036

| Physicial      | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   |   | r (specify)  |  | Month Day Year                    |  |  |  |  |  |  |
|----------------|---|---|--|--|-----------------------------------|--|--|--|--|--|--|
| 2              | Part II. Other significant conditions   |   | 23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown |  |                                   |  |  |  |  |  |  |
| Completed      |   |   |  | 24a. Was an autopsy performed?   |                                   |  |  |  |  |  |  |
|                | 25. Was case referred to medical  | 26. Place of Death (Check only one)                             |  |  |                                   |  |  |  |  |  |  |
| o Be           | examiner?<br>1 ☐ Yes 2☐ No  | Hospital: 1 Inpatient 2 ER/Outpatient 3                         | lome 5 ☐ Residence   | e 5 Residence 6 Other (Specify)  |                                   |  |  |  |  |  |  |
| ation: T       | 27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio   | 28a. Date of Injury<br>(Month, Day Year) 28b. Time of<br>Injury | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No  | 28d. Describe how inju   | 28d. Describe how injury occurred |  |  |  |  |  |  |
| Certification: | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined  |   | 28f. Location (Street a<br>City or Town, Stat  | st. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                                   |  |  |  |  |  |  |
| Medical        | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |  |                                   |  |  |  |  |  |  |
|                | 29b. Signature and the of certifier   | Memale D.O.   | 29c. License number 29d. Date signed (Month, Day, Year) $8.14.07$                                |  |                                   |  |  |  |  |  |  |
|                | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Ami'n Kamuli 122 S. Green St, SII (00, Baltimore MD 7120)  And Mark Day (8a)  33 Pholetrar's Signature  |   |  |  |                                   |  |  |  |  |  |  |

State

Registrar

31. Date filed (Month, Day, Year)

AUG

32. Registrar's Signature

To the Hospital of within 24 hours at To the Funeral D

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2007 Joseph R. Bozicevich, Jr. August 1753 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 27, 1951 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F Director 220-56-0702 55 Japan Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f shov must be notified at 1 □Yes 2 X No Director Maryland Baltimore Owings Mills 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7 F Trolad Court 21117 U.S.A. items 23a Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: "natural", or 1 ☐ Yes 2 ☑ No <u>Ş</u> Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) 5+ of Health and Mental Hygiene. Item 27 is marked other than other traumatic event. the M. Office Administer Dept. of Public Works 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph R. Bozicevich, Sr. Margaret F. Boys ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Brother) David Bozicevich 66 Celts Cove Ruther Glen, VA 22546 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any Injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory 8-16-2007 | Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Linnsee <sup>22</sup> Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine CIRRHOSIS Due to (or as a consequence of): Physician/Medical RENAI IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#102

Registrar

BAZE 7001 31. Date filed (Month, Day, Year) 3 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|  | •  | 1 - For<br>State<br>Registrar  | State o                     | of Maryl           |                                       | artment of H<br>rtificate of L             |                                  | d Mental Hyg                                    | jiene<br>leg. No.                                      | 007                          | 25465                                     |  |  |
|--|--|--|-----------------------------|--------------------|---------------------------------------|--|----------------------------------|---|--|------------------------------|---|--|--|
|  | Physician  1. Decedent's Name (First, Middle, Last)  Elinor B. Bryan |  |                             |                    |                                       |  | Month                            | Date of Death  Month Day Year  August 14, 2007  |  | 3. Time of Death 2:08 A M    |   |  |  |
| /Medic<br>Examin   |  | 4a. Facility Name (If not institution, gi  |                             | 4b. City, Town, or | Location of De                        |  |                                  | unty of Death                                   |  |                              |   |  |  |
|  | ye.  | National Luther  | eran Home                   |                    |                                       | Rocky                                      |                                  | Montgomery                                      |  |                              |   |  |  |
| Funeral<br>Director  |  | 318-26-8638  | Sex<br>1 □ M 2 <b>X</b> 0 F | 7. Age (In )<br>92 | yrs. last birthday)<br>Yrs.           | If Under 1 Year<br>Months Days             | If Under 24 H                    | Hrs. 8. Date of Birth<br>(Month, Day<br>Jan. 29 | , 1915   | 9. Birth<br>Cou<br>111       | place (State or Foreign<br>ntry)<br>inois |  |  |
| land ow  |  | Usual Residence of Decedent  10a. State 10b. County  |                             | 10c.               | City, Town or Lo                      | ocation                                    |                                  |   |  |                              | 10d. Inside City Limits                   |  |  |
| Manylan<br>I-f ehow  | tor  | Maryland Montgo  | nerv                        |                    |                                       | Rocky                                      | 7i11e                            |   |  |                              | 1 ☐ Yes 2X No                             |  |  |
| th the   | Director   | 10e. Street and Number   |                             |                    |                                       | 10f. Zip Code                              |                                  |   | 10g. Citizer   | of What Cou                  | intry?                                    |  |  |
| ath w  | rai  | 9701 Veirs Driv  |                             |                    |                                       | 208  |                                  |   |  | ted St                       |   |  |  |
| Item   | Funeral  | 11. Marital Status 1 ☐ Never Married 2 ☐ Married   | 12. Was Dec<br>Armed Fo     | orces?             | n U.S. 13.                            | Was Decedent of Hi<br>If Yes, specify Cuba | spanic Origin?<br>n, Mexican, Pu | ? (Specify Yes or No-<br>uerto Rican, etc.)     | 14.  | Race - Amer<br>Black, White  |   |  |  |
| should be filed within 72 hours effer death with the Maryland and Mental Hygiene. In a feet death with the Maryland madwaled other than "naturel", or iteme 23a or 28a-f ehow imarked other than "naturel", or items 23a or 28a-f ehow imartic event, the Madrical Examinar must be nutillied.   | þ  | 3 ☑ Widowed 4 ☐ Divorced   | If Yes, Gi<br>Year or E     | ve                 |                                       | 1 ☐ Yes 2 X No                             | Specify:                         |   | Sp   | pecify: Wh:                  | ite                                       |  |  |
| 72 ho  | Completed  | 15. Decedent's f   |                             |                    | (Give                                 | dent's Usual Occupa                        | turing most of                   | working   | 16b. Kind  | of Business/li               | ndustry                                   |  |  |
| within<br>ane.<br>then   | mp   | Elementary/Secondary (0-12)  |                             | 1-4or 5+)          | life.                                 | DO NOT use retired                         | )                                |   |  | O II                         |   |  |  |
| filed v<br>Hygie<br>other  | မ<br>ငိ  | 17. Father's Name (First, Middle, Las  | t)                          |                    | HC                                    | memaker                                    | 18. Mother's                     | Name (First, Middle,                            | Maiden Su  | Own Ho                       | ome                                       |  |  |
| uld be<br>fental<br>rked c   | To B   | Edward Rohlen  |                             |                    |                                       |  | Hann                             | ah E. Olai                                      | nder   | ,                            |   |  |  |
| 2 shou<br>and N<br>Is man  |  | 19a. Informant's Name/Relationship   | (Type, Print)               |                    | 19b. Maili                            | ng Address (Street a                       | and Number of                    | r Rural Route Numbe                             | r, City or To  | own, State, Zi               | p Code)                                   |  |  |
| end 2<br>eeeth<br>m 27<br>her tra  |  | Terry Bryan/Son  |                             |                    | 14825                                 | Rocking                                    | Spring I                         | Drive, Roc                                      | kvill  | e, Mar                       | yland 20853                               |  |  |
| Peges 1<br>nent of H<br>int: If Ite  |  | 20a. Method of Disposition 1   Burial 2 □ Cremation 3  |                             | State              |                                       | matory or other plac                       | AU                               | iguet 22  |  | tion - City or T             |   |  |  |
| 그 문문을 .  |  | 4 □ Donation 5 □ Other (Spec<br>21. Signature) of Funeral Service Lice   | •                           | C                  |                                       | ff Cemeter                                 |                                  | 2007  | COCKIO   | Botho                        | llinois                                   |  |  |
| Depermine Permine Perm |  | IRJ An   | _                           | MO                 | 0 <b>1</b> 98 75                      | bert A. I                                  | oumphre                          | y Funeral<br>., Bethesd                         | Home,  | Chase                        |   |  |  |
| 2 2  |  | 23a. Part1. Einer the disease, or con<br>shock, or heart failure. List only  | nplications that            | caused the c       | leath. Do not en                      | ter the mode of dyin                       | g, such as care                  | diac or respiratory an                          | rest,  | 20014                        | Approximate<br>Interval Between           |  |  |
| Physician  |  | Immediate Cause (Final disease or condition resulting in death)  |                             | UMOI               |                                       |  |                                  |   |  |                              | Onset and Death                           |  |  |
| /Medical<br>Examiner   |  | 1000 ming in dodain,   |                             |                    | sequence of):                         | cla. m                                     |                                  |   |  |                              |   |  |  |
|  | Jer  | Sequentially list conditions, if any, leading to immediate   |                             |                    | sequence of):                         | EMENT                                      | 1.6                              |   |  |                              |   |  |  |
| ocuted<br>nd<br>transit  | Examiner   | cause. Enter Underlying Cause (Disease or injury that initiated events   |                             | RKIN               |                                       | DISCASE                                    |                                  |   |  |                              |   |  |  |
| cate be executed physicien and the burial-transit  | ai Ex  | resulting in death) Last   | Due to                      | (or as a con       | sequence of):                         |  |                                  |   |  |                              |   |  |  |
| icate<br>physics the l   | edicai   |  | d                           |                    |                                       |  |                                  |   |  |                              |   |  |  |
| h certi  | N/W  | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, ou             |                    |                                       | 75   |                                  |   | 230  | I. Date of deliv             | very                                      |  |  |
| IFFEMALE: 23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   23c. If yes, outcome of pregnancy   1  |  |  |                             |                    |                                       |  | Month Day Year                   |   |  |                              |   |  |  |
| thet the   |  | 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                             |                    |                                       |  |                                  | 23e Did to                                      | 23e. Did tobacco use contribute to the cause of death? |                              |   |  |  |
| uires thet<br>signed to<br>ld be deta  | d by   | y art in. Other Significant Contact and Co |                             |                    |                                       |  |                                  |   | 1 Yes 2 No 3 Probably 4 Unknown                        |                              |   |  |  |
| The law require page 2 should be page 2 should be completed I  |  |  |                             |                    |                                       |  | 24a. Was                         | n 24b. Were autopsy findings available          |  |                              |   |  |  |
| ding Physicien: The lav<br>h.<br>After this certificete hes<br>funeral director, page 2  | mo   |  |                             |                    |                                       | -  |                                  | autop<br>perfor<br>1 ☐ Yes                      |  | death?                       | ompletion of cause of<br>2 ☐ No           |  |  |
| iclen: The   | Bec  | 25. Was case referred to medicat examiner?   |                             |                    |                                       |  | 26. Place of                     | Death (Check only or                            |  |                              |   |  |  |
| Physic<br>this or  | ertification: To E   | 1 ☐ Yes 2 ☑ No   | 1                           |                    | 2 ER/Outpatie                         | nt 3 DOA                                   |                                  |   |  |                              |   |  |  |
| ding P.<br>After<br>funer  |  | 1 SNatural 5 ☐ Pending (Month, Day Year)   |                             |                    | r) 28b. Time o                        | of 28c. Injun<br>Work                      | 28d. Describe h                  | 28d. Describe how injury occurred               |  |                              |   |  |  |
| Atten  | ifica  | 2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine  | be 28e. Plac                | e of Injury -      | At home, farm, st                     | reet, factory, office                      |                                  |   |  | Vum <i>ber</i> or Au         | ral Route Number,                         |  |  |
| rs after or el Dir   | Cert   |  | build                       | ling, etc. (Sp     | овспу)                                |  |                                  | City or Tow                                     | m, State)  |                              |   |  |  |
| To the Hospitel or Attending Physicien: The law requires that the death certification 24 hours attended the control of the function of the completely filled in by the funeral director, page 2 should be detached for use as  | edical   | (Check only 2 Medical Exa  | miner: On the l             | pasis of exam      | knowledge, deat<br>nination and/or in | th occurred at the tin                     | ne, date and pl                  | lace, and due to the o                          | ause(s) an   | nd manner as<br>ace, and due | stated.<br>to the cause(s)                |  |  |
| o the<br>ithin 2<br>o the  | Med  | one) 29b. Signature and title of certifier   | and mar                     | nner stated.       |                                       | 29c. License                               |                                  |   |  | signed (Month                |   |  |  |
| Muche Anny MO DOOSIISS AUGUST  |  |  |                             |                    |                                       |  |                                  | 14 2007   |  |                              |   |  |  |
| ,  |  | 30. Name and address of person wh  |                             |                    |                                       |  | `                                |   |  |                              |   |  |  |
| Ø  |  | VATTI AWITTONY   | 9701                        |                    | RS DRI                                | VE S                                       | LOCKVI                           | LL L  | M 0 2  | 10850                        |   |  |  |
| Sta  | te   | 31. Date liled (Month, Day, Year)  | 17 6                        | Registrar's S      | ignature /                            | A. a                                       |                                  |   |  |                              |   |  |  |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|            |  |                  | 1 - For State Registrar  | State                          | or wary  | yland / Dep<br><i>Ce</i>  | artment<br>ertificate  |                     |                                     | ia ivier                          |                                   | g. No.   | ) [                     | 20400                      |
|------------|--|------------------|--|--------------------------------|--|---|--|---------------------|-------------------------------------|-----------------------------------|-----------------------------------|--|-------------------------|----------------------------|
|            | Physici<br>/Medic  |                  | Decedent's Name (First, Middle     Irma Bradford   |                                |  |   |  |                     |                                     | -                                 | Date of Death<br>Month<br>ugust 2 | Day  | Year                    | 3. Time of Death 5:45 AM M |
|            | Examir   |                  | 4a. Facility Name (If not institution  Dove House  |                                | ım <i>ber</i> )  |   |  | Town, or L          | ocation of D                        |                                   | <u> </u>                          | 4c. County o   |                         |                            |
| 1          | Funeral<br>Director  |                  | 5. Social Security Number  415-56-1989  6. Sex  1 M 2 F 7. Age (In yrs. last birthde   |                                |  |   | If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. (Month, |                     |                                     | Date of Birth (Month, Day, 11y 7, | 9. Birthplace (State or I         |  | ntry)                   |                            |
| DQ Z       | how<br>how   |                  | Usual Residence of Decedent  10a. State  10b. County   |                                | 10   | Oc. City, Town or L   | ł 🗀  |                     |                                     |                                   |                                   |  | 10d. Inside City Limits |                            |
|            | ith the Ma<br>or 28s-f   | Irecto           | MD         Carrol1         Taneytown           10e. Street and Number         10f. Zip Code         10g. Citizen of What Court   |                                |  |   |  |                     |                                     | nat Cour                          | 1 Tyes 2 No                       |  |                         |                            |
|            | r death w  | Funeral Director | 4732 Babylon R   | load<br>12. Was Dec<br>Armed F | cedent Eve   | r in U.S. 13.   | Was Deced  | ent of His          | 21787<br>panic Origin<br>Mexican, P |                                   | Yes or No-<br>an, etc.)           |  |                         | can Indian,                |
|            | nours afte   | by               | 1 ☐ Never Married 2 ☐ Mar<br>3 ※ Widowed 4 ☐ Divorced  | ned 1 ☐ Yes                    | 2X No<br>ive   |   | 1□Yes 2  |                     | Specify:                            |                                   | ,                                 | Specify:   |                         | ite                        |
|            | be filed within 72 hours after death with the Maryland tal Hygiene.  ad Hygiene do the mature!', or iteme 23a or 28a-f ehow do then then "nature!', or iteme 23a or 28a-f ehow event, the Madical Examinating at a conflict  | To Be Completed  | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)   |                                |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  housekeeping |  |                     |                                     |                                   | 1                                 | 16b. Kind of Business/Industry                           |                         |                            |
|            | id be filed<br>ental Hygid<br>ked other<br>ic event, II  |                  | 17. Father's Name (First, Middle,<br>Charlie Sparks  | Last)                          |  |   | iousek   |                     |                                     | s Name (F                         | irst, Middle, M                   | <u>motels</u><br>aiden Sumame                            |                         | unk                        |
| Mary       | d 2 should<br>th and Men<br>?7 ie marke<br>traumatic   |                  | 19a. Informant's Name/Relations Donald White/s   |                                |  |   | •  |                     |                                     |                                   |                                   | City or Town, S  |                         | Code)                      |
| saltimore, | nit. Pages 1 end 3<br>entment of Heelth<br>ortant: if item 27<br>injury or other tr.   |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (S  | 3 □Removal from                | State  | 20b. Place of Disp<br>cemetery, cre   | BADY I<br>osition (Nam<br>matory or oti                                    | LOD K<br>her place) | oad Ta                              | aney t<br>Date                    | own, M                            | D 2178<br>0c. Location - C                               | ity or To               | own, State                 |
| Balt       | Depertit<br>Depertit<br>Imports<br>any inju  |                  | 21. Signature of Funeral Service Ronal d   | Licensee<br>Wade,              | irec   | tor   | Name and<br>tate<br>Baltim   | Anato<br>Anato      | of Facility<br>Dmy Bo<br>MD 2       | oard<br>21201                     | 655 W.                            | Baltimo  | re                      | Street                     |
| E          | ificate be executed by Medical Examiner  Standing the primal transit as the primal trans | edical Examiner  | 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, beart failure. List only one cause on each line.  Approximate Interval Between Onset and Death  Preumtong  Due to (or as a consequence of):  Due to (or as a consequence of):  Chick the first provided by the consequence of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Chick the first provided by the  |                                |  |   |  |                     |                                     |                                   |                                   |  |                         |                            |
| . DOX      | death cert<br>e attending<br>d for use   | hysician/Me      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ NO 9 ☐ Unknown  |                                | birth 2 ☐<br>nant at tim                               | Fetal death 3   | ⊒Ectopic pre<br>⊒ Other (spe   |                     |                                     |                                   |                                   | 23d. Date<br>Mont  |                         | ery<br>Day Year            |
| cords, r   | w requires that the de<br>been signed by the a<br>should be detached f   | Completed by Ph  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to   |                                |  |   |  |                     |                                     |                                   |                                   |  |                         |                            |
| VIIAI REC  | The law<br>ete has b<br>page 2 sl  |                  | 24a. Was an autopsy prior to compete the second sec |                                |  |   |  |                     |                                     |                                   | or to co                          | psy findings available mpletion of cause of              |                         |                            |
|            | To the Hospital or Attending Physicien: within 24 hours eller death. To the Funerei Director: After this certific completely filled in by the funeral director.  | atlon: To Be     | 25. Was case referred to medica examiner?  1 Yes 2 Volo  27. Manner Death 1 Datural 5 Pendir 2 Accident investi  |                                | 28c. Injury at Work? 28d. Describe how injury occurred |   |  |                     | DOVE                                |                                   |                                   |  |                         |                            |
|            | tal or Atters of the considerate of Directo of in by the   | Certificati      | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, ste building, etc. (Specify)  |                                |  |   | reet, factory,   |                     |                                     |                                   | Location (Stre<br>City or Town,   | (Street and Number or Rural Route Number,<br>own, State) |                         |                            |
|            | the Hospi<br>tin 24 hou<br>the Funer<br>pletely fill   | edical           | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |                                |  |   |  |                     |                                     |                                   |                                   |  |                         |                            |
| ì          | With<br>To T   | Σ                | 29b. Signalure and title of certifier  29d. Date signed (Month, 08-09)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) color dure, Wentminger IND  |                                |  |   |  |                     |                                     | -2007                             |                                   |  |                         |                            |
|            |  |                  |  |                                |  |   | Privile  | eilm                | dur                                 | e, V                              | varn                              | ninster  | اس                      | 21157                      |
|            | Sta<br>Registr   |                  | 31. Date filed (Month, Day, Year)  | 7 2007                         | Registrar's  | Signature   | f H  |                     |                                     |                                   |                                   |  |                         |                            |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 4.30 AM **Physician** S BALAN JANICE 2007 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTOMORE N/A HOSPITAL OF SINAL BALTIMORE Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 02/12/1932 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2□F Days Hours MD 75 Birector 31 212-28-6431 Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits ortant: if item 27 is marked other then "natural", or items 23a or 28a-1 show njury or other traumatic event, the Madical Examinat must be notified at HOWARD 1 Yes 2 No MD COLUMBIA Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6336 CEDAR LANE 21044 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Specify: WHITE 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry SOCIAL SECURITY it of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATION 12 CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **JACOB** BALAN MINNIE ROSEN ٥ JAMICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1022 DONINGTON CIRCLE - BALTIMORE, MD 21204 CLARA BALAN / SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MEN permit. Page Department o Important: If any Injury or 08/16/2007 WOODLAWN, MD 21. Signature of uneral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician usuliater /Medical Due to (or as a consequence of Examiner Sequentially list conditions. Examiner Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical ģ 2 Be Medical Certification: To 2

or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu filled in by

| if any, leading to immediate case. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c.  Due to (or as a consequence of):  d.  |  |  |  |  |  |  |  |
|---|---|--|--|--|--|--|--|--|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                                     |   | Ectopic pregnancy Other (specify)  | 2  | 3d. Date of delivery<br>Month Day Year   |  |  |  |  |
|   | contributing to death but not resulting in the burnic Renal fail                                | underlying cause given in Part I.  |  | se contribute to the cause of death?  No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No |  |  |  |  |
| 25. Was case referred to medical examiner?  |   | 26. Place of D   | eath (Check only one)  |  |  |  |  |  |
| 1 ☐ Yes 2 (XI)No  | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) |  |  |  |  |  |  |  |
| 27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigati  | 28a. Date of Injury (Month, Day Year) 28b. Time of Injury                                       |  | 28d. Describe how injury   | cocurred   |  |  |  |  |
| 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine   |   |  | Location (Street and Number or Rural Route Number,<br>City or Town, State) |  |  |  |  |  |
| 29a. Certifier 1 Certifying F (Check only one)  | "  " " " " " " " " " " " " " " " " " "  | th occurred at the time, date and plant occurred at the time, date and plant occurred to the control of the control occurred to the control occurred t | ce, and due to the cause(s) courred at the time, date and                  | and manner as stated.<br>place, and due to the cause(s)  |  |  |  |  |

State Registrar

DHMH 17 Rev 1/2001

To the I

29b. Signature and title of certifie

30. Name and address of

AMANDEER

29c. License number

person who completed cause of death (Item 23a) (Type, Print) INAI HOSPITAL BALTIMORE 32. Registrar's Signature

M.D

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 07 Month **Physician** 11 10:10p M William Cornish /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner NA Future Care Homewood Baltimore Birthplace (State or Foreign Country) If Under 1 Year | II Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □XM 2 □ F Months Days Hours 219-05-7566 Yrs. Director 90 Md Usual Residence of Decedent the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State r than "natural", or Itams 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Md. NA Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3134 Cliftmont Avenue 21213 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZW No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎇 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) 7th grade Arrabber Huskster itam 27 is marked other other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cornish Sarah Hampton George ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Olivia Cornish 3134 Cliftmont Ave., Baltimore, Md. f Health Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō = 5 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐Donation 5 ☐ Other (Specify) Md. Nat. Mem. Pk. 8-17-07 Laurel, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F.H. East ladys 1101 E. North Ave., Baltimore, Md. 21202 w anne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1200 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner otel with Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed attending physicien and for use as the burial-transit Moderate Exami Due to (or as a consequence of) P.O. Box 68760, Sten Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Hiknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an s certificete has t lirector, page 2 s autopsy performed 2 🗆 No 1 Yes 2 No 1 TYes or Attending Physicien: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 EP/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No investigation 2 Accident within 24 hours after death To the Funeral Diractor: completely filled in by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier 1 🗲 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

alta

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



MI

N. EUTAW

29c. License number

31464

29d. Date signed (Month, Dey, Year)

ST Snite 308 BALTIMORE MD 2(28)

|                                |  |                  | 1 - State Amend Item 28e, per me, g870,08/16/0/dl  | of Health and M<br>of Death   | lental Hygid<br>Reg                            | ene<br>. No 2 0 0 7  | 26460  |
|--------------------------------|--|------------------|--|---|--|--|--|
|                                | Physici  | an               | 1. Decedent's Name (First, Middle, Last)   |   | 2. Date of Death<br>Month                      | DayYear  | 3. Time of Death                                   |
|                                | /Medic   |                  | Ik C. Choi   |   | August   | 2 <sup>Day</sup> 2007 <sup>ear</sup>   | 9:05 pм  |
|                                | Examin   | er               |  | wn, or Location of Death ysville                                    |  | 4c. County of Death Baltimor   | 2  |
| -                              | Funeral  |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1.  | Year If Under 24 Hrs.   | 8. Date of Birth                               | 0 Riethr   | lace (State or Foreign                             |
| Ы                              | Director   |                  | 215-11-9803   12AW 221   52 Yrs.   | Days Hours Min.   | March Day 2                                    | ;"/1955 CK   | brea   |
|                                | land<br>ow   |                  | Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location   |   |  | 1  | 0d. Inside City Limits                             |
|                                | a-f sh   | ctor             | Md. Baltimore Cockeysville   |   |  |  | 1 ⊡Yes 2X No                                       |
|                                | th with the<br>23a or 28<br>ust be not   | Funeral Director | 10e. Street and Number<br>10301 Malcolm Circle Apt F   | ode<br>030  | 10g  | . Citizen of What Cour<br>Kore   | ′  |
| 36                             | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance. | by Fune          | 11. Marital Status  1  Never Married 2 Married  3  Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:  | nt of Hispanic Origin? (Sp<br>Cuban, Mexican, Puerto<br>No Specify: | ecify Yes or No-<br>Rican, etc.)               | 14. Race - Americ<br>Black, White,<br>Specify: Kor   | etc.   |
| 9                              | 72 hou<br>natura<br>lical E  | ted              | 15. Decedent's Education 16a. Decedent's Usual C (Specify only highest grade completed) (Give kind of work of  | Occupation  | ring 16  | ib. Kind of Business/Ind   | dustry   |
| 21                             | ne.<br>han "r<br>Med   | Completed by     | Elementary/Secondary (0-12) College (1-4or 5+)  12  College (1-4or 5+)  Self Employ  | done during most of work<br>retired)<br>VO                          | ang  | Business   | Nwner  |
| d 2                            | filed w<br>Hygie<br>Ither t  |                  | 17. Father's Name (First, Middle, Last)  | <u> </u>  | e (First, Middle, Ma                           |  |  |
| <u>a</u>                       | lid be<br>lental<br>ked o  | To Be            | Unknown  | Unkn  |  | ,  |  |
| Mary                           | alth and North   |                  | 19a. Informant's Name/Relationship (Type. Print)  Mr. Chin S. Kim/ Friend  19b. Mailing Address (S   | olm Circle  | ral Route Number, C<br>Apt E. Co               | City or Town, State, Zip<br>CKeysville   | , Md. 21030  |
| Baltimore, Maryland 21215-0036 | Pages 1 annent of He   |                  | 20a. Method of Disposition  1 🔀 Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition (Name cametery, crematory or othe Norbeck Mem. Gd   | er place)   |  | lo. Location - City or To  | wn, State  |
| Balt                           | permit. Departr Importa any injl   |                  | 21. Signature of runeral Sarvice Licensee  | Address of Facility Full<br>K Towson Full<br>O York Rd.             | neral Hom<br>Towson, M                         | a: 21204   |  |
| 24.                            | Physician /Medical Examiner  | Examiner         | 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of).  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury hat initiated events  c.  | y Hangin  | 5  | //   | Approximate<br>Interval Between<br>Onset and Death |
| 8760,                          | icate be executed physician and the burial-transit   | dical            | resulting in death) Last  Due to (or as a consequence of):  d.   | CERTIFICATION APPROVE   | DBI  |  |  |
| P.O. Box 6                     | eath certif<br>attending<br>for use as   | Physician/Me     | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specion of the pregnancy)  |   |  | 23d. Date of delive  | ery<br>Day Year                                    |
|                                | w requires that the de<br>been signed by the<br>should be detached   | by               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause  | e given in Part I.  | 23e. Did toba                                  | cco use contribute to the  |  |
| Vital Records,                 |  | Completed        |  |   | 24a. Was an<br>autopsy<br>performe<br>1□ Yes 2 | prior to co<br>death?  | psy findings available mpletion of cause of        |
| Vita                           | Physician: Th<br>r this certificate<br>ral director, pag   | Be               | 25. Was case referred to medical examiner?  Hospital:  | Other:  | th (Check only one)                            |  |  |
|                                | ding Phys<br>T.<br>After this<br>funeral di  | <u>ا</u> ک       | 1 Inpatient 2 EH/Outpatient 3 DOA  | Other: 4 Nursing Ho Injury at Work?                                 | ome 5 Residence<br>28d. Describe how           | ce 6 Other (Specification of the control of the con | y)   |
| Division or                    | Hanging'   |                  |  |   |  |  |  |
| i≤i                            | I or Attenc<br>after death<br>Director:<br>I in by the   | Certification:   | 2 Accident investigation   Accident   Suicide   Accident   Suicide   Accident   ffice   | 28f. Location (Stree<br>City or Town,          | 4 1  | Royte Number                                       |
| Ω                              | ospital c<br>hours af<br>uneral D<br>ly filled i   |                  | Home  29a. Certifier 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the control of t  |   | Cockeys  | solle, MdZ   | 0201   |
|                                | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune  | Medical          | 29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the desired of the death occurred at the death  |   |  |  |  |
|                                | To the within 2 To the comple  | Me               | 29b. Signature and title of certifier 29c. L   | icense number   | 290  | I. Date signed (Month,   | Day, Year)   |
| /                              |  |                  | I layfully MD Deputy DI  | 8667  | A  | igust 5,2  | 007  |
|                                | 5)   |                  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | CILLether   | ville A  | ugust 5,2<br>11) 2109  | 23   |
|                                | Sta<br>Registr   |                  | 31. Date filed (Nogth, Day, Year)  AUG 1 6 2007  32. Registrar's Signature   |   |  |  |  |

|                            |  |                   | = State<br>Registrar  | partment of Health and Nertificate of Death   |  | ene<br>g. No. 2007                            | 26570   |
|----------------------------|--|-------------------|---|---|--|---|---|
|                            | Physic<br>/Med   |                   |   | AN COSTANTINO   | 2. Date of Death   |   | 3. Time of Death 5:50A M  |
|                            | Exami<br>Funeral   | ۲                 | 4a. Facility Name (If not institution, give street and number)  GILCHRIST CENTER  5. Social Security Number  6. Sex  7. Age (In yrs. last birthdom)   | Months Days Hours Min   | 8. Date of Birth (Month, Day,  | 4c. County of Deat  Baltimore  9. Birt        |   |
| 7007                       | Director   |                   | 218-10-9553   |   | Feb 8, 1   | 1004  | 10d. Inside City Limits   |
| 15+15,<br>08/2/            | death with the Maryland The Saa or 28a-f show Thust be notified at   | Funeral Director  | Maryland Baltimore County  10e. Street and Number  6626 Charlesway  | Towson  10f. Zip Code  21204  | 10   | g. Citizen of What Co                         | 1 □ Yes 2 XNo<br>untry?   |
| 0036                       | ite  | þ                 | 3 Widowed 4 Divorced If Yes, Give Year or Dates:  | Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto     □ Yes 2 No Specify:        |  |   | e, etc.   |
| N7/N0 $A$ d 21215-0036     | filed within 72<br>Hygiene.<br>other than "natent, the Medica  | e Completed       | (Specify only highest grade completed) (Gillie Elementary/Secondary (0-12) College (1-4or 5+)   | cedent's Usual Occupation ve kind of work done during most of work by Do NoT use retired  18. Mother's Name | ng   |   |   |
| 20574N<br>Maryland         | 2 should be and Mental is marked o   | To Be             | John E. McClellan  19a. Informant's Name/Relationship (Type. Print) 19b. Ma   |   | . Ellis  | ·   | lip Code)   |
| ore,                       | Pages 1 and pent of Health of: If Item 27 y or other tr  |                   | Mr. James P. Protzman (Son) 662  20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 2.  | 6 Charlesway, Towso position (Name of rematory or other place)  | on, Maryl  | and 21204<br>oc. Location - City or           | Fown, State   |
| しのドル<br>Baltimo            | permit Pag<br>Department<br>Important: If<br>any injury o  |                   | 21. Signature of Funeral Service Vicensey   | idge Cenetery 8/18/<br>MTTCHELL-WIEDEFELD<br>6500 York Road, Bal  | FINERAT  | ikesville,<br>HOME, INC                       |   |
| 8760, 7                    | Physician /Medical Examiner physician and physician and the priral-transit   | dical Examiner    | 23a. Part1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, litery kading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Common disease of conditions, litery kading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | nter the mode of dying, such as cardiac o   | r respiratory arres  | t,  | Approximate Interval Between Onset and Death Days  Days  Days  DAYS |
| P.O. Box 68                | that the death certifica<br>led by the attending ph<br>detached for use as th  | Physician/Medi    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 4 □ Pregnant at time of death 5   | □Ectopic pregnancy □ Other (specify)  |  | 23d. Date of deliv                            | very<br>Day Year  |
|                            | w requires that<br>been signed b<br>should be dete   | by                | Part II. Other significant conditions contributing to death but not resulting in the  | underlying cause given in Part I.   | 23e. Did tobac   | cco use contribute to                         | the cause of death?   |
| Division or Vital Records, | Hospital or Attending Physician: The law requires that the death certific 24 hours after death. Funeral Director: After this certificate has been signed by the attending p tely filled in by the funeral director, page 2 should be detached for use as | 0                 | 25. Was case referred to medical examiner?  1 □ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpatie  | 26. Place of Death  |  | No 1 Yes                                      | opsy findings available impletion of cause of 2 No                  |
| Division or                | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2   | Certification: To | 27. Magner of Death   28a. Date of Injury   28b. Time   2   Accident   3   Suicide   4   Homicide   4   Homicide   2   ER/Outpatiet   2   ER/Outpatiet   2   ER/Outpatiet   2   28a. Date of Injury   28b. Time   Injury   28b. Time   Injury   28b. Time   28c. Place of Injury - At home, farm, stouliding, etc. (Specify)  | of 28c. Injury at Work? 1 Yes 2 No  | le 5 ☐ Residence 8d. Describe how  8f. Location (Stree City or Town, S | injury occurred                               |   |
| (A)                        | To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the  | Medical Ce        | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal check only one)  Certifying Physician: To the best of my knowledge, deal check only one)  American Certifying Physician: To the best of my knowledge, deal check only one)   | ath occurred at the time, date and place, a nvestigation, in my opinion, death occurred                     | nd due to the caus   | se(s) and manner as s<br>and place, and due t | stated.<br>o the cause(s)   |
|                            |  |                   | 29b. Signature and title of certifier  30. Name and address of person who completed cause of death (item 23a) (Type   | 29c. License number   | A  | Date signed (Month,                           | 7.08.7  |
|                            | 3<br>Sta   |                   | 30. Name and address of person who completed cause of death (Item 23a) (Type 701 N C 31. Date filed (Month, Day, Year)  | Print) Leveles St Tows  | ON MO  | 21204   |   |
|                            | Registr  | ar                | AUG 1 7 2007 Steeler At Age   | de  |  |   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Eleanor Donoghue Cole 8:35 PM 2007 August 11, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville <u> 14401 Traville Gardens Circle #210</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. (Month, Day, Year) May 4, 1923 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Social Security Number **Funeral** 1 □ M 2 🛛 F New Jersey 84 Director 140-18-8357 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 ☐ Yes 2X No ns 23a or 28a-f sh must be notified Rockville Director Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with United States 20850 items 23a 14401 Traville Gardens Circle #210 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married ō 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 X Divorced "natural" Completed er than "natur , the Medical B 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M Title Insurance Abstractor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor S. Jefferys Thomas J. Donoghue ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4320 Lake Forest Court, Finksburg, Maryland 21048 Scott D. Cole/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. August 14, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Inc. 2007 Crematorium, 21. Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, M00198 300 West Montgomery Avenue, Rockville, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Instantly Physician Sudden Cardiac Death resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to inmodulate cause. Enter Underlying Cause (Disease or injury that initiated exects.) Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1□Yes 2⊠No 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Hypertension Essential 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementia autopsy performed? 1 ☐ Yes 2 ☐ No 1□ Yes 2√ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ▼ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA မ this nours after death.

neral Director: After this
filled in by the funeral d 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours af To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

1141

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 7 2007

Anurita Mendhiratta,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 2401 Research Blvd.,#330, Rockville, Maryland 20850

D38262

August 13, 2007

Carrie Davis State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Medical Examiner Carrie Davis 1347 hrs August 10, 2007 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital Baltimore 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYY 9. Birthplace (State or Director Months Days Hours oreign 184-22-3475 M 2 XF 79 9-20-1927 Country) S.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show must be notified at once, Md. death with the Maryland NA Director Baltimore 1x Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1025 N. Kenwood Avenue 21205 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Yes 2X No hours after Divorced 3 X Widowed If Yes, Give Year 1 Yes 2 No specify: ۵ Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry Elementary/Secondary (0-12) during most of working life. DO NOT use retired) Pages I and 2 should be filed within 72 College (1-4 or 5+) Baltimore, MD 21215-0036 7th grade NA of Health and Mental Hygiene.
If item 27 is marked other the Domestic Engineer Hospital 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Jack event, Price, Sr. Be Caroline Thompson 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adell Carter Sister 1025 N. Kenwood Ave., Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, tant: If it Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State crematory or other place Department Donation 5 Other Specify: King Mem. Pk. 8-17-07 Randallstown, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 21202 Physician failure. List only one cause on each line Approximate Interval /Medical Between Onset and a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner Death or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examine Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical ned by the attending physician detached for use as the burial -UNPENDED AMENDED Hospital or Attending Physician: The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy past 12 months? Fetal death 2 Month Day Pregnant at time of Other (Specify, 1 Yes 2 No 9 ✔ Unknown death Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 V Unknown Completed s been s 24a. Was an 24b. Were autopsy findings available has 2 sl autopsy prior to completion of cause of certificate performed? death? Yes 2 V No Yes Division of Vital 25. Was case referred to medical Be 26.Place of Death (Check only one) Hospital: Otherthis ۵ Inpatient 1 V Yes 2 V ER/Outpatient 3 No DOA Nursing Home 5 Residence 6 After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred ✓ Natural Pending filled in by the 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City determined Homicide 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 17, 2007 30. Name and address of person who completed cause of death (Item Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

ORIGINAL

COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Douglas J. Dellinger 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month August 15, 2007 0348 hrs Medical Examiner Douglas J. Dellinger 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Howard Columbia Howard General 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Country) MD July 1,1987 Director 214-27-1828 20 1X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No 28a-f show Howard Woodstock MD notified at once. death with the Maryland rector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21163 10421 Hardwood Court 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No 12. Was Decedent Ever in U.S. Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be White, etc. Armed Forces? 1 X Never Married 2 X No Yes 5 White Snecify: If Yes, Give Year Yes 2X No specify: Widowed Divorced Examiner þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene l other than " 21215-0036 Student 2 Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) marked Joseph S. Dellinger Judi A. Douglass Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) If item 27 is 9 Joseph S. Dellinger (Father) 10421 Hardwood Court Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, Crestlawn Memorial Cremation 3 Removal from State 1 X Burial 2 8-18-2007 Marriottsville,MD Gardens Other Specify: Donation 5 Name and Address of Facility Vitzke Funeral Homes, 5555 Twin Knolls Road Signature of Funeral Service Licensee MO1051 Inc. Columbia, 23a. Part I. Enterwire disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Death /Medical a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical tending physician a use as the burial -UNPENDED AMENDED Box 68760, 23d Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy Day Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 V No 3 Probably 4 Unknown þ ted Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? has 1 🗸 Yes 2 2 No 1 🗸 Yes certificate h 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> examiner? DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 Yes No 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Aug 15, 2007 Driver auto auto collision Certification 0230 hrs Natural Yes 2 ✔ No Pending Director: d in by the f 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) Route 99 @ Tavern Court, Ellicot City, MD 3 determined (Specify) Major Road Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 16, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 **OCME 2006** 

OCME

| John Sanford Dist   | 1             | - For State   | State                 | of Marylar                 |                                 | rtment of<br>tificate of           |                                 | and Me                     | ntal Hy       |                    | g. No. 20                               | 07                    | 2647   |
|---|---------------|---|-----------------------|----------------------------|---------------------------------|------------------------------------|---------------------------------|----------------------------|---------------|--------------------|---|-----------------------|--|
| Physiciar   |               | Registrar<br>1. Decedent's Name (First, Mi                    | ldle,Last             | )                          |                                 |                                    |                                 |                            | 2             | 2. Date of Deat    | h                                       | 3.                    | Time of Death                                  |
| Medical Examin  |               | John Sanfo  |                       | Disbro                     |                                 |                                    |                                 |                            |               | Month<br>August 14 |   |                       | 1611 hrs                                       |
|   |               | 4a. Facility Name (if not institu<br>University Hospital      | _                     | street and num             | ber)                            | ľ                                  | b. City, Town Baltimore         |                            | n of Death    |                    | 4c. County of I                         |                       |  |
| Funeral   |               | 5. Social Security Number                                     | 6. Se                 | x 7                        | . Age (In yrs. Ia               | ast birthday)                      | If Under 1 `                    |                            | nder 24Hrs.   | 8. Date of Bir     |   | g. Birthpla<br>oreign | ace (State or                                  |
| Director  | 1             | 218-76-2494   | 1 X                   | M 2 F                      | 48                              | Yrs                                |                                 | Days Ho                    | urs Min.      | OCT 8              |   | Countr                | y) MA  |
| <b>A</b>  |               | Usual Residence of Decedent                                   |                       |                            | 10a Cibi                        | Town or Locati                     | -                               |                            |               |                    |   | Tác                   | d. Inside City Limits                          |
| ow any  |               | 10a. State 10b. Coun  |                       | nde1                       |                                 | evern                              | on                              |                            |               |                    |   |                       | Yes 2 X No                                     |
| Aaryland<br>28a-f show<br>1.at once   | 흱             | 10e. Street and Number  | ALU                   | iide1                      |                                 | evern                              | 10f. Zip Cod                    | e                          |               | . 1                | og. Citizen of What                     |                       |  |
| Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. | Director      | 7933 Barnhi   | 11 0                  | ircle                      |                                 |                                    | 2114                            |                            |               |                    | USA                                     | ,                     |  |
| h with  | Funeral       | 11. Marital Status  | Morriod               | 12. Was Dece<br>Armed For  |                                 |                                    | s Decedent of<br>es, specify Cu |                            |               | cify Yes or No     | 14. Race - White,                       |                       | Indian, Black,                                 |
| er deat   | [편            | Never Married 2  Widowed 4 X                                  |                       | 1 Yes<br>If Yes, Give Year | 2 <b>X</b> No                   |                                    | Yes 2 X                         |                            |               |                    | Specify:                                | Whit                  | t e  |
| urs aft<br>tural"   | 핡             | 15. Decedent's Education (S                                   | _                     | or Dates:                  | completed)                      | 16a. Deceder                       | t's Usual Occi                  | upation (Gi                | ve kind of wo |                    | 16b. Kind of Busin                      |                       |  |
| 5<br>72 hou<br>m "nai   | Completed     | Elementary/Secondary (0-1                                     | 2)                    | College (1-                | 4 or 5+)                        | · ·                                | ost of working                  | life. DO No                | OT use retire | ed)                | 12 10                                   |                       | •  |
| 5-0036 led within 7 Hygiene. other than   | 틹             | 11  |                       |                            | <u>-</u>                        | Painte                             | r                               | 14044                      | 1.31          | er a kadata k      | Remode                                  | Ling                  |  |
| 215-(<br>be filed and Hyg<br>rked oth   | ပို<br>မြ     | 17. Father's Name (First, Midd<br>John Sanfo                  |                       | Disbro                     | w. Sr.                          |                                    |                                 |                            |               | Stanfo             |   |                       |  |
| 212<br>212<br>Ments<br>mark<br>ic even  |               | 19a. Informant's Name/Relation                                |                       |                            |                                 | 19b. Mailing                       | Address (S                      |                            |               |                    | ber, City or Town,                      | State, Zi             | p Code)  |
| MD<br>id 2 shc<br>lith and<br>in 27 is  |               | Emerson Disbr   | ow -                  | brothe                     |                                 |                                    |                                 |                            |               |                    | e, Maryla                               |                       |  |
| or Lean Stranger Heal Heal If item  |               | 20a. Method of Disposition  1 Burial 2 X Crema                | ion 3                 | Removal from               |                                 | Place of Dispos<br>crematory or ot |                                 | f cemetery,                |               | Date               | 20c. Location - C                       | ity or To             | wn, State                                      |
| Baltimore,<br>permit Pages I ar<br>Oceaniment of Hee<br>Important: If the   |               | 4 Donation 5 Other  | Specify:              |                            | Me                              | tro Cre                            | ematory                         | , Inc                      | 8/1           | 6/2007             | Baltim                                  | ore,                  | MD   |
| Balt<br>permit<br>Depart<br>Impor<br>injury   |               | 21. Signature of Funeral Serv                                 | ever                  | PeH. Wil                   | liams                           | 22.1                               | ame and Add<br>Cremat           | tess of Fac                | ociety        | of Ma              | ryland,<br>timore, l                    | Inc.                  | 21 220   |
| Physician   | +             | 23a. Part I. Enter the disease                                | or comp               | lications that car         | used the death                  | . Do not enter t                   | he mode of dy                   | ing, such a                | s cardiac or  | respiratory arr    | est, shock, or hear                     |                       | Approximate Interval                           |
| /Medical failure. List only one cause on each line.   |               |   |                       |                            |                                 |                                    |                                 | Between Onset and<br>Death |               |                    |   |                       |  |
| Examiner  |               | or condition resulting in death                               |                       | Due to (or as a            |                                 | f):                                |                                 |                            |               |                    |   |                       |  |
|   | ا چ           | Sequentially list conditions, if any, leading to immediate    | b.                    | Due to (or as a            | consequence o                   | f):                                |                                 |                            |               |                    |   | $\dashv$              |  |
|   | Examiner      | cause. Enter Underlying Cau<br>(Disease or injury that inmate | se c                  |                            |                                 |                                    |                                 |                            |               |                    |   |                       |  |
| rted<br>d<br>ansit  | Exa           | events resulting in death) La                                 |                       | Due to (or as a            | consequence o                   | f):                                |                                 |                            |               |                    |   |                       |  |
| be executed isician and urial - transit   | dical         | XUNPENDED   | X                     | AMENDED                    | 28a-f n                         | erME,g873                          | 3 11/6/07                       | 7 יייף                     |               |                    |   |                       |  |
|   | š             | IF FEMALE:  |                       | 23c. If yes, o             | utcome of preg                  | nancy                              | 7 11/ 0/ 0/                     |                            |               |                    | 23d. Date of d                          |                       |  |
| 687<br>certifi  | cian/Me       | 23b. Was decedent pregnant i<br>past 12 months?               | ıne                   | 1 Live bit                 | th<br>int at time of de         | oth =                              | etal death<br>ther (Specify)    | 3 Ect                      | opic pregnan  | псу                | Month                                   | Day                   | Year   |
| Box 68760<br>e death certificate b<br>the attending phys  | S I           | 1 Yes 2 No 9  | Jnknown               |                            |                                 | 3 0                                | ner (Specily)                   |                            |               |                    |   |                       | 7/   |
| Records, P.O. Box 6876( The law requires that the death certificate cate has been signed by the attending physpage 2 should be detached for use as the bage 2   | by Phy        | Part II. Other significant cor                                | ditions               | contributing to            | death but not r                 | esulting in the                    | underlying cau                  | ise given in               | Part I.       |                    | obacco use contrib                      | _                     |  |
| of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach.   | 힣             |   |                       |                            |                                 |                                    |                                 |                            |               |                    |   |                       | Unknown  |
| ord<br>aw reg<br>as bee<br>2 shoul  | Completed     |   |                       |                            |                                 |                                    | "                               |                            |               | 24a. Was           | osy pri                                 |                       | osy findings available<br>apletion of cause of |
| Rec<br>The la<br>icate h  | 틹             |   |                       |                            |                                 |                                    |                                 |                            |               | 1 V Yes            |   | Yes                   | 2 No   |
| n of Vital Records,<br>ting Physician: The law requin<br>After this certificate has been si<br>funeral director, page 2 should k  | 8             | 25. Was case referred to med<br>examiner?                     |                       | lospital: 1 🗸 In           |                                 | ER/Outpatien                       |                                 | Other                      | ath (Check o  | nly one)<br>Home 5 | Residence 6                             | Other:                |  |
| of Vi   | 의             | 1 ✓ Yes 2 No<br>27. Manner of Death                           |                       | 28a. Date o                | of Injury                       | 28b. Time of                       |                                 | Injury at W                |               |                    | how injury occurred                     | ,                     |  |
| Sion C<br>Attending<br>death.<br>ector: Af  | 틸             |   | ending                | 8/11/2                     | Day,Year)                       | 11:23 r                            | ym 1[                           | Yes 2                      | X No          | unk                |   |                       |  |
| Division tal or Attendi us after death. al Director: /  | ertification: | 2 Accident In 3 Suicide 6 X C                                 | vestigati<br>ould not | 28e Place                  |                                 | ome, farm, stre                    |                                 | ice building               | , etc.        | 28f. Location (    | Street and Number                       | or Rural              | Route Number, City                             |
| Dir<br>e Hospital of<br>24 hours al<br>e Funeral E  | 팅             | 4 Homicide  | etermine              |                            | found or                        | n street                           |                                 |                            |               | 1352 B (           | State)<br>Edenton Rd.                   | Oden                  | ton, MD  |
| Division of Vital I To the Hospital or Attending Physiciau: within 24 hours after death. To the Funeral Director: After this certifi  | edical        |   |                       | :On the basis o            | f examination a                 |                                    |                                 |                            |               |                    | se(s) and manner a<br>and place, and du |                       | ause(s)  |
| To with   | š             | 29b. Signature and title of cer                               | tifier                | and manner sta             | ated.                           |                                    | 29c. Lic                        | cense numb                 | per           |                    | 29d. Date signed                        | (Month                | , Day, Year)                                   |
|   |               | Dama M  | Dino                  | Con the                    |                                 |                                    | 0                               | .C.M.E.                    |               |                    | August 15, 2                            | 2007                  |  |
|   |               | 30. Name and address of per                                   |                       |                            |                                 |                                    | . D- 2:                         | A - D - 11                 |               | 2.04004            |   |                       |  |
|   |               | Donna M. Vincenti,<br>31. Date filed (Month, Day, Ye          |                       | Assistant M                | edical Exar<br>gistrar's Signat |                                    | 1 Penn Str                      | eet, Balt                  | ımore, MI     | J 21201            |   |                       |  |
| Sta<br>Registr  |               | 31. Date filed (Month, Day, Ye                                | 7 20                  | Wa .                       | Succession of the second        | & Apr                              | we                              |                            |               |                    |   |                       |  |
| DHMH 17 Rev 1/20  | 01            |   |                       |                            |                                 | ORIGINA                            | L                               |                            |               |                    |   |                       |  |

12+1

State Registrar

31. Date filed (Month, Day, Year)

AUG 1

Deborah J. Barbour, M.D., 5454 Wisconsin Ave., #925, Chevy Chase, Maryland 20815 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

|                   |  | -                | For<br>State<br>Registrar   |   | State of Ma   | aryland / I                      |                     | artment of<br><i>tificate o</i>                         |                                       |                      |                                       | giene<br>leg. No.     | 307   | 26477  |
|-------------------|--|------------------|---|---|---|----------------------------------|---------------------|---|---------------------------------------|----------------------|---------------------------------------|-----------------------|---|--|
|                   | Discostati   |                  | 1. Decedent's Name  |   | st) /   |                                  |                     |   |                                       | 2.                   | Date of Dea<br>Month                  |                       | Year  | 3. Time of Death                                   |
|                   | Physicia<br>/Medic   | al -             | Frede   |   | Edulards  | , >L,                            |                     |   | · · · · · · · · · · · · · · · · · · · |                      | 80                                    | 13                    | 2007  | 6:00 PM  |
| 1                 | Examin   | eı               | 4a. Fecility Name (III<br>Baltimore   |   | e street and number)  | nter                             |                     | 4b. City, Town Baltin                                   | , or Location (<br>かのよ已               | of Death             |                                       | 4c. Co                | unty of Death   |  |
|                   | Funeral<br>Director  |                  | 5. Social Security No. 217-56-9   | umber 6. S                                  |   | 9 (In yrs. last bi<br>55         | rthday)<br>Yrs.     | If Under 1 Yea<br>Months Day                            |                                       |                      | Date of Birth<br>(Month, Day<br>10/04 | 1/1951                | 9. Birthp<br>Cour<br>TN   | place (State or Foreign<br>htry)                   |
|                   | pu   | -                | Usual Residence of<br>10a. State  | Decedent<br>10b. County                     |   | 10c. City, Tow                   | m or Lo             | cation  |                                       |                      |                                       |                       |   | I Od. Inside City Limits                           |
|                   | Maryla<br>f eho  | 5                | MD  | Baltimo                                     | ore   | Caton                            |                     |   |                                       |                      |                                       |                       |   | 1 Yes 2  |
|                   | with the 3a or 28e-  | Funeral Director | 10e. Street and Nun 701 Fern  |   | Circle Apt  | . 4                              |                     | 10f. Zip Code<br>21228                                  |                                       |                      |                                       | 10g. Citizen          | of What Coul  | ntry?  |
| 920               | a within 72 hours after death with the Maryland<br>liene.<br>r then "natural", or iteme 23a or 28e-f ehow<br>the Mudical Examiner must be notified at  | þ                | 11. Marital Status 1 □ Never Marri 3 □ Widowed  | ed 2024Married                              | 12. Was Decedent<br>Amed Forces?<br>Yes 2 1<br>If Yes, Give<br>Year or Dates. | 10                               |                     | Was Decedent of Yes, specify Co                         |                                       |                      | Yes or No-<br>an, etc.)               |                       | Race - Americ<br>Black, White,<br>ecify: Whi                    | etc.   |
| 21215-0036        | within 72 ho<br>lene.<br>'then "natur<br>ine Medical   | Completed        | (Spec   | 15. Decedent's Edify only highest grand     | ducation<br>ide completed)  College (1-4or 5                                  | +)                               | (Give               | dent's Usual Occ<br>kind of work dor<br>DO NOT use reti | e durina mos                          | st of working        |                                       |                       | of Business/In<br>Company                                       |  |
| and 21            | be filed<br>tal Hyg<br>d other<br>event,   | a B              | 17. Father's Name (   |   |   |                                  |                     |   |                                       | er's Name <i>(Fi</i> |                                       |                       | mame)   |  |
| Maryland          | d 2 shouth and M   | 2                | 19a. Informant's Na<br>Ann Edwa   |   | Type, Print)  |                                  |                     | ng Address (Stre  |                                       |                      |                                       |                       |   | Code)  |
| Baltimore,        | of Hea   |                  |   | _   | Removal from State  | cemete                           | ry, cren            | sition (Name of<br>matory or other p<br>ake Crem        |                                       |                      | ıg 15                                 |                       | ion - City or To  | own, State<br>Maryland                             |
| Balti             | permit. Pag<br>Department<br>Important: I<br>eny Injury o  |                  | 21. Signature of Fu   | neral Service Licer                         | Retter ME   | 1443                             |                     | Name and Add<br>Cremation<br>8717 Gree                  |                                       |                      | Altern                                | ative:                | s<br>ore, Ma  | ryland 21286-                                      |
|                   |  |                  | 23a. Part1. Enter the   | ne disease, or com<br>rt failure. List only | plications that caused<br>one cause on each li                                | the death. Do                    | not ent             | er the mode of d  | lying, such as                        | cardiac or re        | spiratory ar                          | rest,                 |   | Approximate<br>Interval Between                    |
| +                 | Physician  |                  | Immediate Cause (   | Final                                       | a Citra   | hosis                            | C                   | 1 live  | 7                                     |                      |                                       |                       |   | Onset and Death                                    |
|                   | /Medical<br>Examiner   |                  | resulting in death)   | (   | Due to (or as   | a consequence                    | of): (              | 1   |                                       |                      |                                       |                       |   |  |
|                   | 1  | e.               | Sequentially list con<br>if any, leading to im-<br>cause. Enter Unde<br>Cause (Disease or | nditions,<br>mediate                        | b. Due to (or as  | a consequence                    | abl                 | use   |                                       |                      |                                       |                       |   |  |
| 19                | cuted  | Examiner         | that initiated events   |   | С.  |                                  |                     |   |                                       |                      |                                       |                       |   |  |
| 687605            | icate be executed<br>physicien and<br>s the burial-transit   | ai Ex            | resulting in death) t   | Last  | Due to (or as   | a consequence                    | of):                |   |                                       |                      |                                       |                       |   |  |
| .89               |  | Aedicai          |   |   |   | -                                |                     |   |                                       |                      |                                       |                       |   |  |
| P.O. Box          | To the Hospital or Attending Physicien: The law requires that the death certification at the fours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Physician/M      | IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown                             | months?                                     | 23c. If yes, outcome<br>1 □ Live birth<br>4 □ Pregnant at<br>9 □ Unknown      | 2 Fetal deat                     |                     | Ectopic pregna<br>Other (specify)                       |                                       |                      |                                       | 23d                   | . Date of deliv<br>Month  | ery<br>Day Year                                    |
|                   | w requires that<br>been signed by<br>should be deta  | þ                | Part II. Other signif   | icant conditions of                         | contributing to death b   | ut not resulting                 | in the u            | nderlying cause   | given in Part                         | l.                   |                                       | obacco use<br>′es 2□N |   | the cause of death?                                |
| of Vital Records, | The law requate has been page 2 shoul  | Completed        |   |   |   |                                  |                     |   |                                       |                      |                                       |                       | 4b. Were auto<br>prior to co<br>death?<br>1 \(\sum \text{Yes}\) | opsy findings available ompletion of cause of 2 No |
| /ita              | siclen: Th<br>certificate<br>rector, pag   | Be               | 25. Was case refer examiner?  |   | Hospital:   |                                  |                     | 1   | Othor                                 | e of Death (C        |                                       |                       |   |  |
| of                | Physic<br>rthis<br>ral dir   | 2                | 1 Yes 2 2   |   | 28a. Date of Inju   | ont 2 ☐ ER/O                     | utpatier<br>Time of | II SU DON   |                                       |                      | 5 Resid                               |                       | Other (Speci  | fy)  |
| O                 | th.<br>: After<br>s funer  | ation            | VZNatural<br>2 ☐ Accident   | 5 Pending investigatio                      | (Month, Da  | y Year)                          | Injury              |   | njuryat<br>Vork?<br>□Yes 2□           |                      |                                       |                       |   |  |
| Division          | il or Attendi<br>aftar death.<br>I Director: A<br>d in by the fu   | Certification:   | 3 Suicide<br>4 Homicide   | 6 Could not be determined                   | 28e. Place of Inj   | ury - At home, f<br>c. (Specify) | arm, str            | reet, factory, office                                   | Ce C                                  | 28f.                 | Location (S<br>City or Tox            |                       | lumber or Run   | al Route Number,                                   |
|                   | To the Hospital or Attandi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu   | Medical C        | 29a. Certifier<br>(Check only<br>one)   |   | nysician: To the best<br>niner: On the basis o<br>and manner st               | examination a                    |                     |   |                                       |                      |                                       |                       |   |  |
|                   | To the To the comp   | ž                | 29b. Signature and  | title of certifier                          | 11 00   | )                                |                     | 29c. Lice   | ense number                           |                      | 1                                     |                       | igned (Month,   | Day, Year)   |
|                   |  |                  | Yrunet  | t Gara                                      | otra, MI  | /                                |                     | PI  | 9714                                  | 1                    | (                                     | 08/13                 | 3/07  |  |
|                   | Fx,  |                  | Puncet  | Gandot                                      | completed cause of c  | leath (Item 23a)                 | (Ţype,              | Print) ene St   | reet                                  | Ball                 | mor                                   | e, m                  | D 21  | 201  |
|                   | Sta<br>Regista   |                  | 31. Date filed (Mon   | th, Day, Year)                              | 32. Registr   | ar's Signature                   | bore                |   |                                       |                      |                                       |                       |   |  |

OK HS IS AN ME

|  |   |                  | State of Maryland / D   | Department of He<br>Certificate of D                    |   |                                | ene<br>g. No.2 () () 7 | 25478  |
|--|---|------------------|---|---|---|--------------------------------|------------------------|--|
|  | * 1   |                  | Decedent's Name (First, Middle, Last)   | <del>.</del>  |   | Date of Death     Month        |                        | 3. Time of Death                                   |
|  | Physicia<br>/Medic  | - 2              | Norma Arline Earenfight   | t   |   | August                         | 12, 2007               | 8:30 P M   |
|  | Examin  | 3                | 4a. Facility Name (If not institution, give street and number)  | 4b. City, Town, or L                                    |   |                                | 4c. County of Death    |  |
| _  | 15  |                  | Rockville Nursing Home  5. Social Security Number 6. Sex 7. Age (In yrs. last birt)   | Rocks   | If Linder 24 Hrs                        | 8. Date of Birth               | Montgome               | pplace (State or Foreign                           |
|  | Funeral<br>Director   |                  | 1 N OTT =   | Yrs. Months Days  | Hours Min.                              | Month, Day, 1                  | 922 Min                | nesota   |
| 4-   |   |                  | Usual Residence of Decedent   |   |   |                                |                        | 10d. Inside City Limits                            |
|  | arylar<br>show  | _                | 10a. State 10b. County 10c. City, Town  |   |   |                                |                        | 1 Ves 2 □ No                                       |
|  | the M   | ecto             | Maryland Montgomery  10e Street and Number  | Rockville   |   | 10                             | g. Citizen of What Co  |  |
|  | 3a or   | ä                | 303 Adclare Road  |   | 350                                     |                                | Jnited Stat            |  |
|  | death   | Funeral Director | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?  | 13. Was Decedent of His<br>If Yes, specify Cuban        | panic Origin? (Spe                      | city Yes or No-                | 14. Race - Amer        | ican Indian,                                       |
| 36   | or Ite  | by Fu            | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒☐ No If Yes, Give  | 1 ☐ Yes 2 ☒ No  | Specify:                                | ,                              | 04                     | ite  |
| 8  | hours<br>tural'   | q pa             | 3 ☑ Widowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education 16a.  | Decedent's Usual Occupat                                | tion                                    | 1                              | 6b. Kind of Business/l |  |
| 715  | hin 72<br>In "na<br>Medic   | Completed        | (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  | (Give kind of work done du<br>life. DO NOT use retired) | urina most of workir                    | ng                             |                        | ·  |
| 2  | ged with  | ĕ                | 12   I  | Homemaker   |   |                                | Own Home               |  |
| Maryland 21215-0036                        | be file   | Be               | 17. Father's Name (First, Middle, Last)  Iver Singsaas  |   | 18. Mother's Name<br>Christ             | (First, Middle, M<br>ine Hugo  | *                      |  |
| 2  | hould<br>d Mer<br>marke<br>matic  | ည                |   | . Mailing Address (Street ar                            |   |                                |                        | lip Code)  |
| <u>N</u>                                   | nd 2 salth an 27 is r trau  |                  |   | 509 Reliant I   |   |                                | -                      |  |
| altimore,                                  | ss 1 au<br>of Hea<br>Item   |                  | 20a. Method of Disposition 20b. Place of cemeter  | Disposition (Name of                                    | , D                                     | ate 2                          | Oc. Location - City or | Town, State  |
| <u>E</u>                                   | Page<br>ment<br>ant; If<br>ury o  |                  | INDITES   | oriim. Inc.   | 15,                                     |                                | ethesda, M             |  |
| Balt                                       | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. |                  | 21. Signature Funeral Service Licensee  MO0198  | Robert A. 300 West Mon                                  | s of Facility<br>Pumphrey<br>ntgomery A | Funeral<br>Ave., Roo           | Home/Rock              | ville, Inc.<br>20850-2805                          |
|  |   |                  | 23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.                      |   |   |                                |                        | Approximate<br>Interval Between<br>Onset and Death |
|  | Physician   |                  | Immediate Cause (Final disease or condition resulting in death)  a. Lun: Cancer   |   |   |                                |                        | Oriset and Beam                                    |
|  | /Medical<br>Examiner  |                  | Due to (or as a consequence of  | of):  |   |                                |                        |  |
|  |   | je.              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  | of):  |   |                                |                        |  |
| 12   | cufed<br>nd<br>ransit   | Examiner         | that initiated events   |   |   |                                |                        |  |
| 80,  | cate be executed<br>physician and<br>the burial-transit   | E                | resulting in death) Last Due to (or as a consequence of   | of):  |   |                                |                        |  |
| 387  | icate t<br>physic   | dical            | d   |   |   |                                |                        |  |
| X  | leath certific<br>attending p   | n/Me             | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy   |   |   |                                | 23d. Date of del       | ivery  |
| W.   | death   | Physician/Me     | in the past 12 months?  1 ☐ Yes 2 No  9 ☐ Unknown   | 3 □Ectopic pregnancy     5 □ Other (specify)            |   |                                | Month                  | Day Year   |
| P.   | at the  | Phy              | 9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in   | n the underlying course give                            | n in Port I                             | 23e Did tob                    | acco use contribute to | the cause of death?                                |
| Division or Vital Records, P.O. Box 68760% | v requires that the diplement been signed by the should be detached   | by               | Tartin Other significant Contributing to dead but not resulting in  | in the underlying eadse given                           | THE CITY                                | 1 X Ye                         |                        | obably 4 □Unknown                                  |
| 00   | w req   | Completed        |   |   |   | 24a. Was an                    |                        | topsy findings available                           |
| Re   | The fav   | ошь              |   |   |   | autopsy<br>perform<br>1□ Yes 2 |                        | completion of cause of<br>2□ No                    |
| ita  | iclan; Th<br>certificate<br>rector, pag   | BeC              | 25. Was case referred to medical examiner?  |   | 26. Place of Death                      |                                | $\Delta$               |  |
| 7  | Physician;<br>r this certific<br>ral director,  | 은                | 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Ou  | ·   | 4 🔊 Nursing Hor                         |                                | nce 6 Other (Spe       | cify)  |
| UC C                                       | ding F  | ion              | 1 Natural 5 Pending (Month, Day Year)   | Time of 28c. Injury Work'                               | rat<br>?<br>∕es 2 □ No                  | 28d. Describe ho               | w injury occurred      |  |
| /isi                                       | Attending r death. ector; After by the funer  | Certification:   | 3 Suicide 6 Could not be determined 28e. Place of injury - At home, far   |   |   |                                | reet and Number or Ru  | ıral Route Number,                                 |
| ă  | s after<br>al Dire  | Serti            | 4 Homicide determined building, etc. (Specify)  |   |   | City or Town                   | , State)               |  |
|  | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page   | Medical          | 29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated. |   |   |                                |                        |  |
|  | To th<br>withir<br>To th<br>comp  | Me               | 29b. Signature and title of certifier  Andlef   | 29c. License  |   | 29                             | d. Date signed (Mont   | h, Day, Year)                                      |
|  |   |                  | NID NID   | D64   | 024                                     |                                | August 13,             | 2007   |
|  | 1   |                  | 30. Name and address of person who completed cause of death (Item 23a) (Sandeep Sharma, M.D. 10900 connec   |   | #100 Ker                                | nsinaton                       | . Marvland             | 20895  |
|  | Sta   | ate.             | 31. Date filed (Month, Day, Year) 32. Registrar's Signature   | A- No.  | " 100, KEI                              | DINGCON                        | , inty turn            |  |
|  | Regist  |                  | 31. Date filed (Month, Day, Year) 32. Registrar's Signature   | GORGE .   |   |                                |                        |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene Registrar #19b,26 per FH/DR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** JULY Marshall FINE 2007 8 1:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DOVE HOSPICE WESTMINSTER CARROLL 6. Sex 1 **X** M 2 □ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Yrs. 213-88-7374 43 MD 05/11/1964 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notiffied at 1 ☐ Yes 2 No Director MD CARROLL **FINKSBURG** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 2525 BALTIMORE BLVD. #29 21048 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify.WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 🛣 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) DELIVERY PRINTING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **JEROME** FINE SUE BROTMAN ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4800 COYLE ROAD, #104, REISTERSTOWN, MD 21136 19a. Informant's Name/Relationship (Type. Print) int of Health a t: If item 27 is y or other train SUE BROWN / MOTHER 20b. Place of Disposition (Name of 20c. Location - City or Town, State BALTIMORE HEBREW Department of Important: If any injury or once, 4 □ Donation 5 □ Other (Specify) CEMETERY 07/10/2007 REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on act line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician GIODIZSTOMA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending properties for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dether (Specify) HOSPICE 1 Yes 2 Certification: To patient 2 ER/Outpatient 3 DOA 27. Man or of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 🗌 Yes 2 Accident 3 Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) npletely and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1200 30. Name and address of person who completed cause of death (Item 23a) (Type,,Print) Concer Research Building 2 1m16 1550 Orleans Street
Bottomare, MD Johns Holding University Blakeley

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 1 6 2007

Physician /Medical Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event; the M-dical Examiner must be notified at once.

| _ State<br>Registrar   |  |   | (  | Certifica   | ate of                             | Death  |                                  |                                     | Reg.   | No.   | 117  | 13 5   | 481                                       |
|--|--|---|--|---|------------------------------------|--|----------------------------------|-------------------------------------|--|---|--|--|---|
| . Decedent's Name (First, Middl  |  |   |  |   |                                    |  |                                  | 2. Date of Month                    |  | Day   | Year   | 3. Ťime  | of Death                                  |
| Thom   | - ()   | res   | 11000  |   |                                    |  |                                  | Avg                                 | 15+  | 111   | 007  | 1:35   | SP M                                      |
| a. Facility Name (If not institution   | n, give street and nu  | imber)  |  | 4b. Ci  | ity, Town, c                       | or Location o  | of Death                         | ر وا                                |  | 4c. Count   | ty of Death  |  |   |
| Social Security Number   | 6. Sex   | 7. Age (In  | yrs. last birth  |   | der 1 Year                         |  |                                  | 8. Date o                           | f Birth  |   | 9. Birth   | hplace (Stat   | e or Foreig                               |
| 065-20-2013  | 1 <b>∑</b> M 2□F   |   | 95 Y   | rs. Month   | ns Days                            | Hours  | Min.                             |                                     | , Day, Ye  |   | 1  | untry)<br>N JER  | SEY                                       |
| Isual Residence of Decedent  Oa. State 10b. County   |  | 100   | . City, Town   | or Location   |                                    |  |                                  |                                     |  |   |  | 10d. Inside  | City Limite                               |
|  | ROLL   |   |  | INSTE   | סי                                 |  |                                  |                                     |  |   |  |  | es 2 X No                                 |
| De. Street and Number  |  |   | VIDITI   |   | Zip Code                           |  |                                  |                                     | 10g.   | Citizen of  | What Co  | untry?   |   |
| 154 ROCKLANI   | מק מ   |   |  |   | 21158                              |  |                                  |                                     | USA  |   | ,  |  |   |
| 1. Marital Status  | 12. Was Dec  |   | in U.S.  | 13. Was De  | cedent of h                        | Hispanic Ori   | gin? (Sp                         | ecity Yes o                         | r No-  |   |  | rican Indian,  |   |
| 1 Never Married 2 Mar  | nied 1 ∑ Yes   | 2 □ No  |  |   | specify Cub<br>s 2 🕱 No            | ,  | i, rueito                        | nican, etc.                         | ,  | Spec  | ack, White   |  |   |
| 3 X Widowed 4 ☐ Divorced   | Year or D  | Dates:WW  | II   |   |                                    |  |                                  |                                     | 4.00   |   | . 4411   | ITE  |   |
| (Specify only highe  | nt's Education<br>est grade completed)   |   | 1  | Decedent's U<br>(Give kind of<br>life. DO NO  | work done                          | during mos   | t of work                        | ing                                 | 160  | . Kind of I   | Business/I   | Industry   |   |
| Elementary/Secondary (0-12) 1 2  | College (  | (1-4or 5+)  | İ  |   | TEAC                               | ,  |                                  |                                     | I  | EDUC  | ATIO   | N  |   |
| 7. Father's Name (First, Middle,   | Last)  |   |  |   |                                    | 18. Mothe  | er's Name                        | e (First, Mi                        | ddle, Mai  | den Surna   | ime)   |  |   |
|  | THOMAS   |   | I  | FLOOD   |                                    | JES  | SE                               |                                     | F  | IAYE  | S  |  |   |
| 9a. Informant's Name/Relations   | ship (Type. Print)   |   | 19b.   | Mailing Addre   | ess (Street                        | t and Numbe  | er or Rur                        | ral Route N                         | umber, C   | ity or Towi   | n, State, Z  | (ip Code)  |   |
|  | -STEP-DA   |   |  | 4 ROC   |                                    | ID RD  |                                  |                                     |  |   |  |  | 88  |
| 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - (1XX) Burial 2 □ Cremation 3 □ Removal from State   |  |   |  |   |                                    |  |                                  |                                     |  |   | - City or  | Town, State  |   |
| 1X Burial 2 Cremation 3 Removal from State   |  |   |  |   |                                    |  |                                  |                                     |  |   | •  | •  |   |
| 1X Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (5   | Specify)   | State   | cemetery   | BRANC   | or other pla<br>CH CE              | М. 8   | 1/17                             | /07                                 | WI   | ESTM:   | INST   | ER, N  | 4D  |
| 1X Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (5   | Specify)   | State   | cemetery   | BRANC<br>22. Name   | or other pla<br>CH CE<br>and Addre | M. 8<br>ess of Facilit   | 3/17<br>y FL                     | /07<br>ETCH                         | <br>WI<br>ER I   | ESTM:<br>FUNE:  | INST<br>RAL  | ER, N  | 4D  |
| 1X Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (£<br>21. Sig atul. 15 ☐ Fun al Service  | Specify)<br>Licensee   | State<br>MEA  | ADOW   | BRANC<br>22. Name   | CH CE and Addre                    | M. 8<br>ess of Facilit<br>AIN S  | 3/17<br>FL                       | /07<br>ETCH<br>WES                  | WI<br>ER I<br>TMIN   | ESTM:<br>FUNE:  | INST<br>RAL  | ER, M<br>HOME<br>D 21  | 157                                       |
| 1X Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (S<br>21. Signature of Fundamental Service<br>23a. Part1. Enter the disease, of<br>shock, driheart failure. Lis  | Specify) Licensee  | State ME7   | ADOW   | BRANC<br>22. Name   | CH CE and Addre                    | M. 8<br>ess of Facilit<br>AIN S  | 3/17<br>FL                       | /07<br>ETCH<br>WES                  | WI<br>ER I<br>TMIN   | ESTM:<br>FUNE:  | INST<br>RAL  | ER, N  | 157<br>nate<br>Between                    |
| 1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5 21. Signature of Fund all Service 23a. Part1. Enter the disease, one shock, drive all trailure. Lister the disease of condition disease or condition   | Epecify) Licensee r complications that tonly one cause on  | State MEA   | cemetery ADOW  | BRANC  22. Name  254  ot enter the n  | CH CE and Addre                    | M. 8<br>ess of Facilit<br>AIN S  | 3/17<br>FL                       | /07<br>ETCH<br>WES                  | WI<br>ER I<br>TMIN   | ESTM:<br>FUNE:  | INST<br>RAL  | HOME D 21  | 157<br>nate<br>Between                    |
| 1X Burial 2 Cremation 4 Donation 5 Other (\$21. Sig atur, ** Fuor al Service**  23a. Part1. Enter the disease, o shock, or heart failure. Lis*  Immediate Cause (Final   | Epecify) Licensee r complications that tonly one cause on  | State ME7   | cemetery ADOW  | BRANC  22. Name  254  ot enter the n  | CH CE and Addre                    | M. 8<br>ess of Facilit<br>AIN S  | 3/17<br>FL                       | /07<br>ETCH<br>WES                  | WI<br>ER I<br>TMIN   | ESTM:<br>FUNE:  | INST<br>RAL  | HOME D 21  | 157<br>nate<br>Between                    |
| 1X Burial 2 Cremation 4 Donation 5 Other (September 1) 21. Signature of Fundamental Service 22. Signature of Fundamental Service 23. Part 1. Enter the disease, one shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)  Segmentially list conditions.   | Epecify) Licensee  r complications that tonly one cause on Due to  | State MEA   | ADOW   | BRANC  22. Name  254  ot enter the n  | CH CE and Addre                    | M. 8<br>ess of Facilit<br>AIN S  | 3/17<br>FL                       | /07<br>ETCH<br>WES                  | WI<br>ER I<br>TMIN   | ESTM:<br>FUNE:  | INST<br>RAL  | HOME D 21  | 157<br>nate<br>Between                    |
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| 1  Burial 2  □ Cremation   4  □ Donation 5  □ Other (\$2.5  □ Other (\$3.5  □ Other (\$4.5  □ Othe | Precify) Licensee  r complications that tonly one cause on Due to b. Due to c. Due to d. Due to 4 □ Preg 9 □ Unkr  | caused the ceach line.  (or as a con  (or as a con  (or as a con  itcome pf prebirth 2 □ I  inant at time nown                                      | death. Do not sequence of sequ | BRANC  22. Name  254  ot enter the n  f):  f):  | c pregnanc (specify)               | EM . 8 ess of Facilit AIN S ing, such as   | 3/17<br>by FL<br>ST.,<br>cardiac | JO7 JETCH WES or respirato          | WIER IF  | 23d. D  | RAL R, M  Pate of delification of the control of th | HOME D 21  Approximately a line of the cause | 157 nate Setween Id Death  Year  f death? |
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Registrar
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30. Name and address 4 person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Z9S SP09/ 2. Registrar's Signature

| Privilege Control Main, Last)  Privilege Control Main, Last (Control          |  |  | State of Maryland  | -                             |   |  | lental Hygi                             | iene                        |                              |                          |
|--|---------|--|--|--|-------------------------------|---|--|---|-----------------------------|------------------------------|--------------------------|
| Physician Projects of Flory Company of the part and number of the pa |         |  |  | Registrar  | Ceri                          | tificate of L                                 | Jeath                                      |   |                             | 117                          | 3 Time of Death          |
| Examiner  1. Set Set New Form of Form or distriction, gos actives deviated by the Company of the |         |  |  |  |                               |   |  | Month                                   | Day                         |                              |                          |
| Port of the Control   |         |  |  |  | ,                             | 4b. City, Town, or                            | Location of Death                          |   | 4c. Coun                    | ty of Death                  | 01.01                    |
| 213-54-4926   10x 20   57 vm   thrombour   10x 10x 10x   10x |         |  | H  |  | nter                          |   |  |   |                             | N/A                          |                          |
| The company of the    |         |  |  | 1EXM 2015  |                               |   |  | 8. Date of Birth (Month, Day,           | Year)                       | 9. Birthp                    | lace (State or Foreign   |
| Sample   Company   Compa   |         |  |  |  |                               |   |  | 0-7-13                                  |                             | 30011                        | CAROLINA                 |
| Sample   Company   Compa   |         | irylane<br>show                          | _  | 10a. State 10b. County 10c. City,  | Town or Loc                   | cation  |  |   |                             | 1                            |                          |
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| Sample   Company   Compa   |         | with t                                   | Ö  |  |                               |   | 28   | 10                                      |                             |                              | try?                     |
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| Sample   Company   Compa   | Š       | Phour                                    |  | 15. Decedent's Education   | 16a. Deced                    | ent's Usual Occupa                            | ation                                      |   |                             |                              |                          |
| Sample   Company   Compa   | 2 2     | hin 72<br>e.<br>an "ne<br>Me ii          | plet   | (Specify only highest grade completed)   | (Give k<br>life. D            | kind of work done of<br>OO NOT use retired    | luring most of work<br>)                   | ing                                     |                             |                              |                          |
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| State   1   District   2   Dicension   5   District   1   District   2   Dicension   5   District   1   District   2   District   Dist   | מב      | d be fill<br>ental H<br>ed off           | Be c   |  |                               |   |  |   |                             | ame)                         |                          |
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| State   1   District   2   Dicension   5   District   1   District   2   Dicension   5   District   1   District   2   District   Dist   | , M     | and 2<br>salth a<br>n 27 is<br>er tra    |  | DORETHA FOSTER(SISTER)   | 528                           | ROSSITER                                      | AVE. BAI                                   | LTIMORE,                                | MARYI                       | AND 2                        | 1212                     |
| Physician American Physician American Course (Final Let only one cause or each line.)  Physician American Physician American Physician American Physician Ph | ore     | jes 1 ac He in them                      |  | 1 M Runal 2 D Cromation 2 D Romoval from State   | metery, crem                  | natory or other plac                          | e)   |   |                             |                              |                          |
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| Physician American Physician American Course (Final Let only one cause or each line.)  Physician American Physician American Physician American Physician Ph | מ       | permi<br>Depa<br>Impo<br>any Ir          |  | 21. Signature of Luneral Service Licensee JONATIAN D.  |                               |   |  |   |                             |                              | 77 AND 01017             |
| Physician Medical Examiner  Framiner   ۲       |  |  | 23a. Part. Inter the disease, or complications that caused the death.  |                               |   |  |   |                             | MAR                          | Approximate              |
| Sequentially list conditions, cause. Enter Underlying cause (cheater or night)  To Due to (or as a consequence of):  Due to (or as a consequen |         | Immediate Cause (Final                   |  |  |                               |   |  |   |                             | Onset and Death              |                          |
| Part I Topology of the part I Topology of the |         |  |  | resulting in death)  Due to (or as a conseque  | ence of):                     |   |  |   |                             |                              | ian                      |
| Due to (or as a consequence of):    Due to (or as a consequence of):   |         | Lammer                                   | <u>~</u>   | Sequentially list conditions, if any leading to immediate  |                               | eva   |  |   |                             |                              | 6 weeks                  |
| Section   Control   Cont   | J       | uted<br>d<br>ansit                       | min  | Cause (Disease or injury   |                               |   |  |   |                             |                              |                          |
| FEMALE:   28. Was decedent pregnant   10 page 12 processes   20 page 13 page 14 page   | 5       | e exec<br>ian an<br>ırial-tr             | Exa  |  | ence of):                     |   |  | **                                      |                             |                              |                          |
| FEMALE:   28. Was decedent pregnant   10 page 12 processes   20 page 13 page 14 page   | 0/0     | cate b<br>physic<br>the bi               | dica   | d  |                               |   |  |   |                             |                              |                          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Circle In Grimm 601 South Charles St. Baltimore MD 2:230  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | X       | certifi<br>nding<br>use as               |  | 23c. If yes, outcome of pregnant   | icy                           | -   |  | _                                       | 23d [                       | ate of delive                | erv                      |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Circle In Grimm 601 South Charles St. Baltimore MD 2:230  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | Ď       | death<br>e atte                          | icial  | in the past 12 months?  1 Ves 2 No 4 Pregnant at time of dea   |                               |   |  |   |                             |                              | *                        |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Circle In Grimm 601 South Charles St. Baltimore MD 2:230  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | Э       | at the                                   | Phys   | 9 LI Onknown   |                               |   |  | 1                                       |                             |                              |                          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Circle In Grimm 601 South Charles St. Baltimore MD 2:230  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | S,      | ires th<br>signed                        | þ  | 1  |                               | iderlying cause give                          | en in Part I.                              |   |                             | •                            |                          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Circle In Grimm 601 South Charles St. Baltimore MD 2:230  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | 000     | w requ                                   | etec   | The state of the s | <u> </u>                      |   |  |   |                             |                              |                          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Circle In Grimm 601 South Charles St. Baltimore MD 2:230  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | Ů       | The lar<br>te has<br>age 2               | dwo  |  |                               |   | ·  | autops:<br>perforn                      | y<br>ned2                   | prior to cor<br>death?       | mpletion of cause of     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Circle In Grimm 601 South Charles St. Baltimore MD 2:230  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | מ       | lan:<br>rtifica<br>stor, p               |  | 25. Was case referred to medical   |                               |   | 26. Place of Deat                          |   |                             | 1 Li Yes                     | 2 No                     |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Circle In Grimm 601 South Charles St. Baltimore MD 2:230  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | کر<br>د | hysic<br>his ce                          |  | 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ E   |                               | 1 3 DOA                                       | 4 LI Nursing Ho                            | me 5 Reside                             | nce 6 □C                    | ther (Specif                 | y)                       |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Circle In Grimm 601 South Charles St. Baltimore MD 2:230  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |         | ding P. After t                          | 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Work? |  |                               |   |  |   |                             |                              |                          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Circle In Grimm 601 South Charles St. Baltimore MD 2:230  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |         | Atten                                    | ficat  | e□ Could not be  | ne, farm, stre                |   | 163 2 1140                                 | 28f. Location (Str                      | reet and Nui                | mber or Rura                 | l Route Number,          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Circle In Grimm 601 South Charles St. Baltimore MD 2:230  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | 5       | Ital or<br>rs after<br>ral Dire          | Certi  |  |                               |   |  |   |                             |                              |                          |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Circle In Grimm 601 South Charles St. Baltimore MD 2:230  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |         | e Hosp<br>24 hou<br>e Fune<br>letely fil | dical  | (Check only 2 Medical Examiner: On the basis of examination  | ledge, death<br>on and/or inv | n occurred at the tin<br>vestigation, in my o | ne, date and place,<br>pinion, death occur | and due to the ca<br>red at the time, d | ause(s) and<br>ate and plac | manner as s<br>e, and due to | tated.<br>o the cause(s) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Cardelia I. Grimm 601 South Charles St. Baltimone MD 21230  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |         | To th<br>within<br>To th<br>сопр         | Me   | 29b. Signature and title of conflict   | 1                             | 29c. License                                  | e number                                   | 25                                      | 9d. Date sig                | ned (Month,                  | Day, Year)               |
| State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |         |  | MD D61882 8/10/07  |  |                               |   |  |   |                             |                              |                          |
| State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |         | 2  |  |  | 23a) (Type, F                 | Print)  | nortes                                     | st. B.                                  | Itima                       | ٨ م                          | 10 21230                 |
| Registrar AUC 1 7 2007   |         |  |  |  |                               | 1   | , = 0                                      | . 1200                                  |                             | - T                          |                          |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Aug 16, 2007 Pauline E. Hayes 1:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis of Waldorf Waldorf Charles Watuori If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Nov 6, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕏 F 579 40 2542 93 Virginia Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 7 is marked other than "natural", or Iteme 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director 1 Ves 2 □ No N/A N/A Washington DC 10e. Street and Number 10g. Citizen of What Country? 3417 Martin Luther King Ave S.E. 20032 United States death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. a filed within 72 hours after if Hygiene. other than "natural", or Ite 1 Never Married 2 Married 1 ☐ Yes 2 ▼ No If Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ If Yes, Give A Year or Dates: 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 9th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Wallace Woodyard Roberta Jane Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perry & Flossie Ahlers (P.O.A.) 9405 Caldran Drive, Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery Aug 24, 2007 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera Spons 22. Name and Address of FacilityLee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) Preumonia **Physician** /Medical Due to (or as a consequence of): Failure to thrive **Examiner** months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 🖔 Due to (or as a consequence of) Physician/Medical IF FEMALE: 980 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hyperiension , Aypusty roid ism 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2000No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death | Check only one examiner? 1 ☐ Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐Yes 2 ☐No To the Hospitel or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi 2 Accident investigation 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Sindhuan Hugered 16th DO061616 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R. SINDHIWANI 10 embrooke Square, windorf, MD 11350 31. Date filed (Month, Day, Year) 32. Resistrar's Signature Registrar

State

Registrar

DHMH 17 Rev 1/2001

7601 OSLER DRIVE TOWSON.

MARY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 2007

M. D.

32. Registrar's Signature

KHOSROW TABASSI

AUG 1

31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 13, 2007 ear **Physician** Joan Wise Hitchcock 11:43 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9707 Old Georgetown Rd. #1408 Bethesda Montgomery 8. Date of Birth (Month, Day, Yea June 9, 19 If Under 1 Year If Under 24 Hrs. 6. Sex Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 🖾 F 89 1918 Director 552-26-4968 Missouri Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits items 23a or 28a-f show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director |Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9707 Old Georgetown Rd. #1408 Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the <u>Medical Examiner must</u> onoe. 20814 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: White ρ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Delmar Clark Wise Julia McElroy ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia C. Dahmer/Daughter 2805 Shubert Drive, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State Montgomery August Crematorium, Inc. 16,2007 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. M01346 Bethesda, Maryland 20814 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Euperal Service Licensee 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform 1□ Yes 2**⊠** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 🛭 Residence 6 Other (Specify) ၉ 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

within 24 hours arter common to the Funeral Director; Aft

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State Registrar

Medical

Ira N. Brecher, M.D., 2101 Medical Park Drive #304, Silver Spring, Maryland 20902

31. Date filed (Month, Day, Year)

pature and title of dertifier

29a. Certifier

one)

(Check only

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

manner stated.

by Owe

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

29c. License number

D00428

the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

|                   |   |                | For State  | State of Ma   |   | epartm<br>Certific           |                             | Health and N                                 |   | 7.1                   | 117                          | 261.6   |
|-------------------|---|----------------|--|---|---|------------------------------|-----------------------------|--|---|-----------------------|------------------------------|---|
|                   |   |                | Registrar  1. Decedent's Name (First, Middle   | . Last)   |   | Jeruno                       | ale UI                      | Dealli                                       | 2. Date of Death                          | g. No.                |                              | 3. Time of Death                              |
|                   | Physici   |                | ,  |   | Hanagan   |                              |                             |  | Month<br>August                           | Day                   | Year<br>2007                 |   |
|                   | /Medi<br>Examir   |                | 4a. Facility Name (If not institution  |   | IIaliagali                                      | 4b. C                        | City, Town, o               | or Location of Death                         | August                                    |                       | ty of Death                  | 6:34PM  |
|                   |   |                | Holy Cr  | oss Hospital  | L   |                              | Si                          | lver Spri                                    | ng  |                       | Montg                        | omerv   |
|                   | Funeral   | 151-7          | 5. Social Security Number  |   | e (In yrs. last birth                           | Mont                         | hs Days                     | If Under 24 Hrs.<br>Hours Min.               | 8. Date of Birth (Month, Day,             | Year)                 |                              | place (State or Foreigntry)                   |
| Nice-to           | Director  |                | 579-48-1008  | IN W Z  | 75 Y  | rs.                          |                             |  | July 21,                                  | 1932                  |                              | ew York                                       |
|                   | land<br>bw<br>it  |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town                                 | or Location                  |                             | -  |   |                       | 1                            | 0d. Inside City Limit                         |
|                   | Mary<br>Fish  | Ιō             | Maryland Mon   | ntgomery  |   |                              | (                           | Germantow                                    | n   |                       |                              | 1 ☐ Yes 2 N                                   |
|                   | h the   | Director       | 10e. Street and Number   | in gomery   |   | 10f.                         | Zip Code                    | Jermaneow.                                   |   | g. Citizen of         | Citizen of What Country?     |   |
|                   | th wit  |                | 20 Dru   | mcastle Cour  | ct  |                              |                             | 20876  |   | Ur                    | ited                         | States  |
|                   | tems<br>tems  | Funeral        | 11. Marital Status   | 12. Was Decedent<br>Armed Forces?                                     |   | 13. Was De<br>If Yes,        | ecedent of H<br>specify Cub | Hispanic Origin? (Sp<br>an, Mexican, Puerto  | ecify Yes or No-<br>Rican, etc.)          |                       | ice - Americ<br>ack, White,  |   |
| 21215-0036        | 2 should be filed within 72 hours after death with the Maryland rand Mental Hygiene.  Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at   | by             | 1 ☐ Never Married 2 M Marri<br>3 ☐ Widowed 4 ☐ Divorced  | ed 1X Yes 2 1<br>If Yes, Give<br>Year or Dates:                       | 1950  | 1 ☐ Ye                       | s 2XINo                     | Specify:                                     |   | Spec                  | ify:                         | White   |
| 5-0               | 72 h<br>"natu   | ete            | 15. Decedent<br>(Specify only highes   |   | 16a. E  | Decedent's U<br>Give kind of | Jsual Occup<br>work done    | pation<br>during most of work<br>d)          | ting                                      | 6b. Kind of I         | Business/Ind                 | dustry  |
| 121               | within<br>ene.<br>than  | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5  | 5+)   |                              |                             | o)<br>Officer                                |   | Soour                 | ·ita C                       | ontractor                                     |
| d 2               | filed<br>Hygid<br>ther  | ပ္             | 17. Father's Name (First, Middle,  |   |   | 360                          | urrcy                       | 1  | e (First, Middle, M                       |                       |                              | oncractor                                     |
| Maryland          | ld be<br>ental<br>ked o   | To Be          | Thom   | as Patrick H  | lanagan   |                              |                             |  | Mary Mar                                  | garet                 | Co114                        | ng  |
| ary               | rt tr   | -              | 19a. Informant's Name/Relations  |   |   | Mailing Addr                 | ress (Street                | and Number or Rui                            |   |                       |                              |   |
|                   |   |                | Carol D. Hana  | gan/ Wife   | 2   | 20 Dru                       | mcast                       | le Court,                                    | Germant                                   | own, M                | lary1a                       | nd 20876                                      |
| Baltimore,        |   |                | 20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (Si                       |   | Gate<br>of Hea                                  | , crematory                  | or other pla                | ce) Aug                                      | gust                                      | 0c. Location          | •                            | •   |
| Baltii            |   |                | 21. Signature of Juneral Service   |   |   | 22. Name                     | e and Addre                 | ess of Facility Rob<br>e Inc. 3<br>e Mary 1a | ert A. Pi                                 | umphre                | v Fun                        | g, Maryla<br>eral Home<br>Avenue              |
|                   |   |                | 23a. Part1. Enter the disease, or shock, or heart failure. List  | complications that caused   | M00335<br>I the death. Do no                    |                              |                             |  |   |                       |                              | Approximate                                   |
| d                 | Physician<br>/Medical   |                | shock, or heart failure. List<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | _a Sepsis   |   | cute                         |                             | Cystitus                                     |   |                       |                              | Interval Between<br>Onset and Death           |
|                   | Examiner  |                | Aguta On Chronic Panal Failure   |   |   |                              |                             |  |   |                       |                              |   |
| line.             | 70 ==   | ner            |  |   |   |                              |                             |  |   |                       |                              | <u>-</u>                                      |
| 1.                | cate be executed<br>physician and<br>the burial-transit   | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last                                | с   |   |                              |                             |  |   |                       |                              |   |
| \$760°L           | oe exician a  | ũ              | resulting in deathy Last   | Due to (or as   | a consequence of                                | ·):                          |                             |  |   |                       |                              |   |
| 87                | physic the k  | dical          |  | d   |   |                              |                             | <del></del>                                  |   |                       |                              |   |
| ). Box 6          | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                | 23c. If yes, outcome 1 Live birth 4 Pregnant a                        | 2 Fetal death                                   | 3 □Ectopi<br>5 □ Other       | ic pregnanc<br>(specify) _  | у  |   |                       | ate of delive                | ery<br>Day Year                               |
| P.0               | hat the   |                | Part II. Other significant condition   | ns contributing to death b  | ut not resulting in t                           | the underlyir                | na cause aiv                | ven in Part I                                | 23e. Did tob                              | acco use co           | atribute to th               | ne cause of death?                            |
| ds,               | signe<br>d be   | d by           |  | 3   |   | ,                            | 3                           |  |   |                       |                              | pably 4 ☐Unknow                               |
| or Vital Records, | law requas been 2 shoul   | Completed      |  |   |   |                              |                             |  | 24a. Was an                               | ,                     | . Were auto                  | psy findings availabl<br>mpletion of cause of |
| <u> </u>          | The page  | Sol I          |  |   |   |                              |                             |  | perform<br>1∐ Yes 2                       | ed?<br><b>X</b> I No  | death?<br>1 ☐ Yes            | •   |
| Vita              | lcian<br>sertifi<br>ector,  | Be             | 25. Was case referred to medical examiner?   | Hospital:   |   |                              | Oth                         |  | h (Check only one                         | )                     |                              |   |
| 0                 | ding Physician: The lav<br>n.<br>After this certificate has<br>funeral director, page 2.  | ٦.             | 1 Yes 2X No<br>27. Manner of Death   | 1 N Inpatie   | ·   |                              | DOA Oth                     | 4 🗆 Nursing He                               | ome 5 Resider                             |                       |                              | <u>'y)</u>                                    |
| on                | ding<br>h.<br>After<br>fune   | tion           | 1X Natural 5 ☐ Pending investig  | (Month, Da  |   | ury                          | 28c. Injui<br>Woi<br>1 🗆    | rk?<br>Yes 2 ∐No                             | 200. Describe no                          | w injury occi         | ired                         |   |
| Division          | or Atten<br>after deat<br>Director<br>in by the   | Certification: | 3 Suicide 6 Could n<br>4 Homicide determi  | at he   | I<br>ury - At home, farn<br>c. <i>(Specify)</i> | n, street, fac               | 1                           |  | 28f. Location (Str.<br>City or Town,      | eet and Nun<br>State) | nber or Rura                 | al Route Number,                              |
| _                 | o the Hospital or Attent<br>within 24 hours after death<br>o the Funeral Director:<br>ompletely filled in by the  | Medical Co     | 29a. Certifier  (Check only one)  1  | g Physician: To the best<br>Examiner: On the basis o<br>and manner st | f examination and                               | death occur<br>/or investiga | red at the ti               | me, date and place,<br>opinion, death occur  | and due to the ca<br>rred at the time, da | use(s) and r          | nanner as s<br>e, and due to | tated.<br>the cause(s)                        |
|                   | Fo the<br>Mithin<br>Fo the  | Me             | 29b. Signature and title of certifier  | 1   |   |                              | 29c. Licens                 | se number                                    | 29  | d. Date sign          | ed (Month,                   | Day, Year)                                    |

lot,

State Registrar Estone Musonge-Tarkang, M.D. 1500 Forest Gleen Road, Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D63390

August 15, 2007

Records, P.O. Box 68760, Division or Vital

law requires that the death certificate be executed burial-trar and attending physician for use as the burial signed t page 2 certificate To the Hospital or Attending Physician: within 24 hours after death. funeral director Within 24 hours after ucc....
To the Funeral Director: A

edical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

death with the Maryland

filed within 72 hours after

permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any Injury or other traumatic event, the Medicone.

**Physician** 

/Medical

Examiner

Maryland 21215-0036

Baltimore,

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Examiner

31. Date filed (Mor State Registrar

29a. Certifier (Check only one)

|                                       |  |  |  | autopsy<br>performed?<br>1□ Yes 2 1 10                      | prior to completion of cause<br>death?<br>1 ☐ Yes 2 ☐ No |
|---------------------------------------|--|--|--|---|--|
| red to medical                        |  |  | 26. Place of Dea   | ath (Check only one)  |  |
| No                                    | Hospital: 1 Impatient 2  | ]ER/Outpatient 3 □ D                                 | OA Other: 4 Nursing H  | lome 5 ☐ Residence 6  | □Other (Specify)   |
| h<br>5 □ Pending<br>investigatio      |  | 28b. Time of<br>Injury<br>M                          | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No                      | 28d. Describe how injury                                    | occurred   |
| 6 Could not be determined             | 28e. Place of injury • At he building, etc. (Spec.             | nome, farm, street, factorify)                       | ry, office   | 28f. Location (Street and<br>City or Town, State)           | Number or Rural Route Number,                            |
| 1 ☐ Certifying Ph<br>2 ☐ Medical Exam | ysician: To the best of my kn<br>niner: On the basis of examin | owledge, death occurre<br>ation and/or investigation | d at the time, date and place<br>on, in my opinion, death occu | e, and due to the cause(s) a<br>urred at the time, date and | and manner as stated. place, and due to the cause(s)     |

| n the basis of examination and/or investion distributed in the state of the state o | gation, in my opinion, death occurred at the ti | me, date and place, and due to t |
|--|---|----------------------------------|
|  | 29c. License number                             | 29d. Date signed (Month, Da      |

|     | (Szumien to MD |
|-----|----------------|
| A.1 |                |

ay, Year) DØ\$64792 August 13, 200

20707

29b. Signature and title of certifier

**Physician** /Medical Examiner burial-tra Division or Vital Records, P.O. Box 68760, physician requires that the death certificate be the

Examiner

Physician/Medical

Be Completed by

Certification: To

Medical

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

I Hygiene. other than '

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumatic event, if

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

for use as the þ signed to page 2 should certificate has funeral director, this After t Hospital or Attending hin 24 hours after death the Funeral Director: filled in by

Physician:

Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier,

20

within 7

completely

State Registrar

Appropria 31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Charles St TOWSON MP 2/201

07-06299 Kenneth A. Jacobs

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|  |               | Registral   | Certificate of                          | f Death   | R                                       | eg. No.  |  |  |  |  |  |
|--|---------------|---|---|---|---|--|--|--|--|--|--|
| Physicia<br>Medical Exami  | 411/          | 1. Decedent's Name (First, Middle,Last)  Kenneth Adam Jacobs  |   |   | 2. Date of Dea<br>Month<br>August 18    | Day Year<br>5, 2007                                      | 3, Time of Death<br>1255 hrs                       |  |  |  |  |
|  |               | 4a. Facility Name (if not institution, give street and number) 450 South Chapel Gate Lane   |   | 4b. City, Town, or Location of Death  Baltimore  4c. County of D                                |   |  |  |  |  |  |  |
| Funeral<br>Director  |               | 218-78-8283 1XM 2F  | rs. last birthday) 46 Yrs               | If Under 1 Year If Un<br>Months Days Hou  | , Co                                    | rthplace (State or Foreign<br>ountry)<br>aryland         |  |  |  |  |  |
| Maryland<br>28a-f show any<br><u>d at once.</u>  | ctor          | Usual Residence of Decedent  10a. State  10b. County  Maryland  10e. Street and Number  | City, Town or Locat  Balting            |   |   | l0g. Citizen of What Cou                                 | 10d. Inside City Limits 1 Yes 2 No                 |  |  |  |  |
| with the Maryland<br>ms 23a or 28a-f sho<br>be notified at once.   | Director      | 450 S. Chapelgate Lane  |   | 21229   |   | United Sta   | -  |  |  |  |  |
| MD 21215-0036<br>2 should be fited within 72 hours after death with the Maryland<br>h and Mental Hygiene.<br>27 is marked other than "natural", or items 23a or 28a-f she<br>matic event, the Medical Examiner must be notified at once  | by Funeral    | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed                                   | No If Y                                 | If Yes, specify Cuban, Mexican, Puerto Ricán, etc.)  White, etc.  1 Yes 2 No specify:  Specify: |   |  |  |  |  |  |  |
| 036<br>ithin 72 hour<br>ne.<br>r than "natt  | ompleted      | Elementary/Secondary (0-12) College (1-4 or 5+)   | during m                                | retaker   | T use retired)                          | 16b. Kind of Business/                                   |  |  |  |  |  |
| 21215-0036 buld be filed within 7 Mental Hygiene. marked other than it event, the Medical  | BeC           | 17. Father's Nama (First, Middle, Last)  Norman K. Jacobs   | 302000000000000000000000000000000000000 |   | er's Name (First, Middle,<br>Nora Elois | e Campbell   |  |  |  |  |  |
| nore, MD 21215-0036 ages I and 2 should be filted within 72 he nt of Health and Mental Hygiene. It: If item 27 is marked other than "n; other traumatic event, the Medical E.  | ၉             | 19a. Informant's Name/Relationship (Type, Print) Mrs. Nora Eileen Hall / Siste  | er 406                                  | g Address (Street and No<br>Glenwood Ro   |   | , MD 210   | 14   |  |  |  |  |
| 드다리트루  |               | 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:   | crematory or other Cayview C            | rematory  |   | 20c. Location - City or Town, State  Baltimore, Maryland |  |  |  |  |  |
| Balti<br>permit<br>Departm<br>Imports<br>injury o  |               | 21. Signature of Funeral Service Licensee   | 22.                                     | Name and Address of Facil<br>Hubbard Fune<br>4107 Wilkens                                       | ral Home, I                             | nc.<br>ltimore MD  | 21229  |  |  |  |  |
| Physician<br>/Medical<br>Examiner  |               | Part I. Enter the alsease, or complications that caused the defailure. List only one cause on each line.     Immediate Cause (Final disease a. Atherosclerotic Card |   |   | cardiac or respiratory an               | rest, shock, or heart                                    | Approximate Interval<br>Between Onset and<br>Death |  |  |  |  |
|  |               | or condition resulting in death)  Due to (or as a consequence b.  | ce of):                                 |   |   |  |  |  |  |  |  |
|  | Examiner      | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Co.  |   |   |   |  |  |  |  |  |  |
| cuted<br>and<br>transit  |               | events resulting in death) Last Due to (or as a consequence d.  | ce of):                                 |   |   |  |  |  |  |  |  |
| 760, icate be executed physician and the burial - transit  | Medical       | UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of p  | pregnancy                               |   |   | 23d. Date of deliver                                     |  |  |  |  |  |
|  | Physician/N   | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  22c. If yes, outcome of past 12 we birth 4 Pregnant at time of g Unknown                   | 2 Fe                                    | etal death 3 Ector  | pic pregnancy                           |  | y<br>Day Year                                      |  |  |  |  |
| ires that the signed by the detache  | Š             | Part II. Other significant conditions contributing to death but in Morbid Obesity   | not resulting in the u                  | underlying cause given in I   |   | obacco use contribute to                                 | *****  |  |  |  |  |
| cords,<br>law requir<br>has been s   | Completed     |   |   |   |   | psy prior to death?                                      | utopsy findings available completion of cause of   |  |  |  |  |
| ital Recisions: The scertificate irector, page   | B             | 25. Was case referred to medical examiner?  1   | P ER/Outpatient                         | Othor   | h (Check only one)  Nursing Home 5      | Residence 6 🗸 Othe                                       | ar: Soono  |  |  |  |  |
| for of Vitending Physicath.  The function of Viter this of the function of the this of the function of the fun | ation: To     | 27. Manner of Death 1 V Natural 5 Pending 2 Accident Investigation  | 28b. Time of I                          |   | rk? 28d. Describe                       | how injury occurred                                      | a. Scene   |  |  |  |  |
| Division  To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu   | Certification | 3 Suicide 6 Could not be determined (Specify)   | At home, farm, stree                    | et, factory, office building,   | etc. 28f. Location (<br>or Town, s      | Street and Number or Ri<br>State)                        | ural Route Number, City                            |  |  |  |  |
| To the Hos<br>within 24 h<br>To the Fur<br>completely  | edical        | 29a. Certifier (Check only one) 2 ✓ Medical Examiner: On the basis of examination and manner stated.  |   |   |   |  |  |  |  |  |  |
|  | Ž             | 29b. Signature and title of certifier  Cluck HOLL   | lan                                     | 29c. License numbe  | er                                      | 29d. Data signed (Mo                                     |  |  |  |  |  |
| 67   |               | 30. Name and address of person who completed cause of death (I Carol Allan, MD Assistant Medical Examiner   | r 111 Penn 9                            | Street, Baltimore, M  | D 21201                                 |  |  |  |  |  |  |
| St<br>Regist   | C. C.         | 31. Date filed (Month, Day, Year) 32. Registrar's Sign AUG 1 7 2007   | nature A                                | acel s  |   |  |  |  |  |  |  |
| DHMH 17 Rev 1/20   | 001           | 7.  | ORIGINA                                 | L   |   |  |  |  |  |  |  |

| 0 | , 100 | 1  | 0 | 0 |
|---|-------|----|---|---|
|   |       | 11 | J | U |

|                            |  |   | For State Registrar   |                                    | State of M  | ıaryıan   |                                 |                         | nt of H<br><i>te of L</i> |                            | and Me          | -                                       | giene<br>Rag. No      |                                 |                    | 4090                                  | U     |
|----------------------------|--|---|---|------------------------------------|---|---|---------------------------------|-------------------------|---------------------------|----------------------------|-----------------|---|-----------------------|---------------------------------|--------------------|---------------------------------------|-------|
|                            |  |   | Decedent's Name (Fig. 1)  | irst, Middle, Last,                |   |   |                                 |                         |                           |                            |                 | 2. Date of De                           | ath                   |                                 |                    | 3. Time of Dea                        | th    |
|                            | Physici:<br>/Medic   |   |   | Jerry                              | Thomas  | Jame  | es                              |                         |                           |                            |                 | Month<br>August                         | Da<br>14              | y 2007                          | ır                 | 1:59 P                                | М     |
|                            | Examin   |   | 4a. Facility Name (If not   |                                    |   | nd number) 4b. City, Town, or Location of Death 4 |                                 |                         |                           |                            |                 | . County of De                          | eath                  |                                 |                    |                                       |       |
|                            |  |   | 14 Farm H   | laven Co                           | ırt   | Rockville   |                                 |                         |                           |                            |                 | Montgomery                              |                       |                                 |                    |                                       |       |
|                            | Funeral  |   | 5. Social Security Numb   | _                                  | 2   |   | last birthday)                  | If Und                  | or 1 Year<br>Days         | If Under<br>Hours          | 24 Hrs.<br>Min. | 8. Date of Bir<br>(Month, Da<br>October | h<br>V Year           | 9. 6                            | Sirthpla<br>Countr | ace (State or For                     | reign |
|                            | Director   |   | 415-74-7802   |                                    | M 2 F   | 60  | Yrs.                            |                         |                           | 1.00.0                     |                 | October                                 | 25, 1                 | L946   Te                       | nne                | ssee                                  |       |
|                            | and *  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location |   |                                    |   |   |                                 |                         |                           |                            |                 |   |                       |                                 | 10                 | d. Inside City Lir                    | mits  |
|                            | Aaryli<br>r eho  | ō   |   | Montgome                           | ~17   |   | Rockv                           |                         |                           |                            |                 |   |                       |                                 |                    | 1 ∑ Yes 2 □                           |       |
|                            | 28a-   | Director  | 10e. Street and Number  | <u>~</u>                           | L y   |   | ROCKV                           |                         | ip Code                   |                            |                 |   | 10a Ci                | tizen of What                   | Count              | n/2                                   |       |
|                            | with<br>3a or  |   | 14 Farm H   |                                    | ırt   |   |                                 |                         | 20852                     |                            |                 |   | •                     | ted Sta                         |                    | ,                                     |       |
|                            | ne 2%  | era   | 11. Maritat Status  | aven oo                            | 12. Was Decedent  | Ever in U.  | S. 13.                          |                         |                           | spanic Ori                 | gin? (Spec      | rify Yes or No<br>lican, etc.)          |                       | 14. Race - A                    |                    |                                       |       |
| Maryland 21215-0036        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other then "natural", or Iteme 23a or 28a-f ehow any injury or other traumatic event. The Medical Examinar must be notified at once.  | by Funeral  | 1 Never Married   |                                    | Armed Forces<br>1 K Yes 2 ☐<br>If Yes, Give<br>Year or Dates: | ?<br>No   |                                 | lf Yes, sp<br>1 ☐ Yes   |                           | n, Mexicar<br>Specify:     | i, Puerto R     | lican, etc.)                            |                       | Black, W                        |                    |                                       |       |
| Ō                          | 72 ho  | Completed   | 15.   | . Decedent's Edu                   | cation  |   | 16a. Dece                       | dent's Us               | ual Occupa                | ation                      | e of workin     |   | 16b. K                | (ind of Busine                  | ss/Indi            | ıstry                                 |       |
| 2                          | thin .   | npie  | Elementary/Secondar   | only highest grad<br>ary (0-12)    |   | Ollege (1-40r5+)                                  |                                 |                         |                           |                            | t of workin     | y                                       |                       |                                 | <u> </u>           |                                       |       |
| 7                          | ygien<br>ygien<br>yer th   | ပ်  |   |                                    | 5+  |   | Compu                           | ter                     | Sales                     |                            |                 |   |                       | mputer Corporation              |                    |                                       | n     |
| п                          | tal Hid off  | Be  | 17. Father's Name (Firs   |                                    |   |   |                                 |                         |                           |                            |                 | (First, Middle,                         |                       | n Sumame)                       |                    |                                       |       |
| 3                          | ould<br>Mer<br>Parke   | 2   | Elmer Chris James Alice I  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run |                                    |   |   |                                 |                         |                           |                            |                 |   |                       |                                 |                    |                                       |       |
| ă<br>Z                     | d 2 st<br>th and<br>7 ie r<br>traun  |   | Joan R. Ja  |                                    |   |   |                                 | -                       |                           |                            |                 |   |                       | or rown, state<br>Marylar       |                    |                                       |       |
|                            | 1 and<br>Health  |   | 20a. Method of Disposit   |                                    | LIC   | 20b. P  | lace of Dispo                   |                         |                           |                            | ugust           |   |                       | ocation - City                  |                    |                                       |       |
| Baltimore,                 | t. Pages<br>tment of<br>nant: If it  |   | 1 Burial 2 C C 4 Donation 5   | remation 3 □F<br>□ Other (Specify) |   | ,   | gomery (                        | Crema                   | torium                    | ,Inc.                      |                 | 2007                                    | Bet                   | hesda,                          | Ma                 |                                       |       |
| Ba                         | Depariment Department of the suny in the suny in the suny in the suny in the suny in the sunce of the sun the sunce of the |   | 21. Signature of Funeral  | terani                             | To large  | M013  | 30                              | u wes                   | t Mont                    | gomery                     | Avenu           | ie, Kock                                | VILLE                 | ville, I<br>e, Maryla           | nc.                | 20850–280                             | 5     |
|                            |  |   | shock/or heart failure. List only one cause on each line.   |                                    |   |   |                                 |                         |                           |                            |                 |   |                       |                                 |                    | Approximate<br>Interval Between       |       |
|                            | Physician  |   | Immediate Cause (Fina disease or condition  | al                                 | Hypert  | ensio   | n                               |                         |                           |                            |                 |   |                       |                                 |                    | Onset and Death                       | 1     |
|                            | /Medical<br>Examiner   |   | resulting in death)   |                                    | Due to (or as   |   |                                 |                         |                           |                            |                 |   |                       |                                 |                    |                                       |       |
|                            | Examine  | _   | Sequentially list conditi   | ions,                              | Diabet  |   |                                 | Typ                     | e II                      |                            |                 |   |                       |                                 |                    |                                       |       |
| ٥                          | pe tisi  | ine   | Sequentially list condition any, leading to immediate. Enter Underlyin Cause (Disease or injuries)                          | ng -                               | Duarto (or as   | s a consequ                                       | udrica of).                     |                         |                           |                            |                 |   |                       |                                 |                    |                                       |       |
| $\partial_{\hat{\rho}}$    | and and II-trar  | Examiner  | resulting in death) Last Due to (or as a consequence of):   |                                    |   |   |                                 |                         |                           |                            |                 | -                                       |                       |                                 |                    |                                       |       |
| 2,09289                    | ificate be executed<br>g physicien and<br>as the burial-transit  | E E   |   |                                    |   |   |                                 |                         |                           |                            |                 |   |                       |                                 |                    |                                       |       |
| 687                        | ficate<br>phys<br>s the  | edical  |   |                                    | J   |   |                                 |                         |                           |                            | -               |   |                       |                                 | +                  |                                       |       |
|                            | nding<br>use a   | M   | IF FEMALE:<br>23b. Was decedent pre   | egnant 2                           | 3c. If yes, outcome   |   |                                 |                         |                           |                            |                 |   | 23d. Date of delivery |                                 |                    | v                                     |       |
| Box                        | The law requires that the death certified has been signed by the attending page 2 shruid be detached for use a   | Physician/M   | in the past 12 mor  | nths?                              | 1 ☐ Live birth<br>4 ☐ Pregnant a                              |   |                                 | Ectopic Other (         | pregnancy<br>specify)     |                            |                 |   |                       | Month                           |                    | Day Year                              |       |
| <u>Р</u> .                 | t the<br>by the  | hys   | 9 Unknown 9 Unknown   |                                    |   |   |                                 |                         |                           |                            |                 | -                                       |                       |                                 |                    |                                       |       |
|                            | as tha   | by P  | Part II. Other significan   | nt conditions co                   | ntributing to death   | but not resu                                      | ulting in the u                 | nderlying               | cause give                | n in Part I                |                 | 23e. Did t                              | obacco                | use contribute                  | to the             | cause of death                        | ?     |
| ğ                          | w require<br>been si<br>should b   | pet   |   |                                    |   |   |                                 |                         |                           |                            |                 | 1 🗆 '                                   | Yes 2                 | .⊠No 3⊟                         | Proba              | bly 4 ∐Unkn                           | own   |
| CC                         | law r<br>as be<br>2 sh   | Completed   |   |                                    |   |   |                                 |                         |                           |                            |                 | 24a. Was                                |                       | 24b. Were                       | autop:             | sy findings avail<br>pletion of cause | able  |
|                            | Ti e   | 5   |   |                                    |   |   |                                 |                         |                           |                            |                 |   | rmed?<br>2 No         | death                           | ?                  | !□ No                                 |       |
| ita                        | cien:<br>ertific<br>ector,   | Be  | 25. Was case referred to examiner?  |                                    | -   |   |                                 |                         |                           |                            | of Death        | Check only o                            | ne)                   |                                 |                    |                                       |       |
| _                          | hysi<br>this c   | ဥ   | 1 X Yes 2 □ No  |                                    | 1   |   | ER/Outpatier                    |                         |                           | 4 🗆 140                    |                 |   |                       | 6 ☐Other (S                     | pecify)            |                                       |       |
| ב                          | After<br>unera   | on:   | 27. Manner of Death 1 Natural 5   | Pending                            | 28a. Date of Inj<br>(Month, Da                                | ury<br>ay Year)                                   | 28b. Time of<br>Injury          |                         | 28c. Injury<br>Work       |                            |                 | 8d. Describe                            | how inju              | iry occurred                    |                    |                                       |       |
| S                          | death<br>death<br>tor:<br>, the f  | cat   | 2 Accident 3 Suicide 6  | investigation Could not be         | ORe Diseased to   | i A. b.   |                                 | М                       |                           | Yes 2                      |                 | Pé l'acation (                          | Ct                    | - 4 \$1 6                       | 01                 | 0 1 1                                 |       |
| Division of Vital Records, | s after of Directory   | Certification:  | 4 Homicide  | determined                         | 28e. Ptace of In<br>building, e                               | itc. (Specify                                     | y)                              | reet, racto             | гу, опісв                 |                            | 4               | City or To                              |                       |                                 | Hurai              | Route Number,                         |       |
|                            | To the Noepitel or Attending Physicien: The tay within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2  | Medical (   | 29a. Certifier 1 (Check only one)   | Certifying Phy Medical Exami       | sician: To the best<br>ner: On the basis<br>and manner s      | of examina  | wledge, death<br>tion and/or in | h occurre<br>vestigatio | d at the timen, in my of  | ne, date ar<br>pinion, dea | nd place, ar    | nd due to the<br>d at the time,         | cause(s<br>date an    | s) and manner<br>d place, and c | as sta<br>lue to t | ted.<br>the cause(s)                  |       |
|                            | To th<br>Mithin<br>Fo th   | Me  | 29b. Signature and title  | of dertifier                       | h , '   |   |                                 | 2                       | 9c. License               | number                     |                 |   | 29d. Da               | ate signed (Mo                  | onth, D            | ay, Year)                             |       |
| )                          |  |   | > King  | St.                                | 110   |   |                                 | 1                       | 000                       | 37:                        | 532             |   | A110                  | ust 15                          | . 2                | 007                                   |       |
|                            | 121  |   | 30. Name and address  | of person who co                   | ompleted cause of   | death (Item                                       | 23a) (Type,                     | Print)                  |                           |                            |                 |   | 6                     |                                 | , -                |                                       |       |
|                            | 1041   |   | Praveen K.  |                                    |   |   |                                 |                         | Driv                      | /e, #                      | 202,            | Rockvi                                  | 11e                   | , Maryl                         | and                | 20852                                 |       |
|                            | Sta<br>Registr   |   | 31. Date filed (Month, E  | Day, Year)                         | 7 Regist  | trar's Signa                                      | ture                            | 2000                    |                           |                            |                 |   |                       |                                 |                    |                                       |       |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** RONETTA KNOBLETT August 12:48 PM /Medical 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner AUREL REGIONAL HOSPITAL PG LAUREL county 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 17, 1 6 Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🔽 F 1923 Illinois 578-20-7012 83 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20705 death v Funeral 13112 Taney Drive 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 12 Department of Health and Mental Hygin Important: If item 27 Is marked other I any Injury or other trainment. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roy J. Hammond Florence May Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13112 Taney Drive Beltsville, MD Bern Knoblett/spouse 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald S. Wade, Director

Ronald S. Wade, Director

23a. P. rt1. Enter the seas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Howard University College of Medicine 520 W Street NW Washington, DC 20059 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3days RESPIRATORY **Physician** A DULT DISTRESS /Medical Due to (or as a consequence of): Examiner 30M APPROVED BY MEDICAL EXAMINES Procumoni A S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi). Examine and burlal-tra CERTIFIC Due to (or as a consequence of) Records, P.O. Box 68760 physiclan Physician/Medical the ass attending p for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 I Inknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 FEMUR FRACTURE 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No Division or Vital 25. Was case referred to medical examiner?
Yes 2□ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 5 Pending investigation 1 Natural Injury SUBJECT 1 ☐ Yes 2 No 12:00 PM FELL 7/26/07 hours after death. 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Side-walk 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Side—walk

| 3112 Taney Drive Beets of Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Beetsville, mo 29a. Certifier Medical (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Hospitalist

To the I

Registrar

31. Date filed (Month, Day, Year) AUG 1 6 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

D0064760

8/10/2007

MD-20707

7300 VAN DUSEN ROAD

LAURGL,

|                                   |  |                   | For Amend Items 23a, 25e per me,   | <b>32870,08</b> 7<br>Cer                      | <b>107070hb</b> e<br>tificate of D   | eath                                 | ental Hygie<br>Reg                                 |   | 26492   |  |  |
|-----------------------------------|--|-------------------|--|---|--|--------------------------------------|--|---|---|--|--|
| 0.4                               | Physicia   |                   | 1. Decedent's Name (First, Middle, Last) FRANCES LYNN  | KIEBLE  | R  |                                      | Date of Death Month JULY 11                        | Day Year 7 2007                                 | 3. Time of Death 7:15P M                      |  |  |
|                                   | /Medic<br>Examin   |                   | 4a. Facility Name (If not institution, give street and number) 7914 OAKDALE AVENUE   |   | 4b. City, Town, or Lo  | ocation of Death                     |  | 4c. County of Death                             | IMORE   |  |  |
|                                   | Funeral<br>Director  |                   | 5. Social Security Number 217-50-5490 6. Sex 1□M 2√□F 6.   | yrs. las <i>t birthd</i> ay)<br><b>1</b> Yrs. |  | If Under 24 Hrs. 8<br>Hours Min.     | B. Date of Birth (Month, Day, Y) 12-27-1           | 9. Birthp<br>945 MAR                            | lace (State or Foreign<br>try)<br>YLAND       |  |  |
| Maryland -f show ied at           |  |                   | Usual Residence of Decedent  | . City, Town or Lo                            |  | EDALE                                |  | 1   | 0d. Inside City Limits 1 ☐ Yes 2 No           |  |  |
|                                   | h with the   | al Director       | 7914 OAKDALE AVENUE  | 7   | 10g  | Citizen of What Cour                 | ntry?  |   |   |  |  |
| <b>5-0036</b> 72 hours after deat | 72 hours after death with the Maryland<br>'rnatural', or Items 23a or 28a-f show<br>idical Examiner must be notified at  | d by Funeral      | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 M No if Yes, Give Year or Dates:  |   | Was Decedent of Hisp<br>If Yes, specify Cuban,<br>1 ☐ Yes 2 No   | Specify:                             | 4.00   | or No-<br>Diack, White, etc.  Specify: WHITE    |   |  |  |
| 21215-(                           | i within 72 ho<br>jiene.<br>r than "natu<br>th- Medical  | Completed         | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  1 2   | (Give   | ent's Usual Occupation<br>kind of work done during most of working<br>IO NOT use retired)<br>ITY CONTROL |                                      |  | 16b. Kind of Business/Industry HOPKINS HOSPITAL |   |  |  |
| d 2.                              | Hyg<br>Hyg   |                   | 17. Father's Name (First, Middle, Last)  | 20112   |  |                                      | te (First, Middle, Maiden Surname)                 |   |   |  |  |
| ılan                              | o grap   | To Be             | WILLIAM HARTMAN N  | IZER  |  | FRANCE                               | S  | (WING   | ATE)  |  |  |
| , Maryland                        | s 1 and 2 should<br>f Health and Men<br>item 27 is marke<br>other traumatic  |                   | 19a. Informant's Name/Relationship (Type. Print) HUSBAI<br>HARRY R. KIEBLER, JR.   |   | ng Address (Street an<br>OAKDALE   |                                      | ROSE   | City or Town, State, Zip                        | 21237   |  |  |
| Baltimore,                        | permit. Pages 1 a Department of He Important: If Item any injury or oth  |                   | 1X Burial 2 ☐ Cremation 3 ☐ Removal from State   | BALTIMO                                       | matory or other place) RE CEMET  2. Name and Address   | ERY 7-1                              | 4-07 E<br>CH/ROSE                                  | BALTIMORE EDALE FUN EDALE, MD                   | , MD<br>ERAL HOME                             |  |  |
| و8760, تر                         | Ificate be executed / Medical Examiner   Bhysician and   Bhysician and   Bhysician at the burial-transit   B | ledical Examiner  | 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Diabetes  Due to (or as a cordition of the condition  ion esity CERTIFICATIONA                      |  | 1/1                                  | Approximate<br>Interval Between<br>Onset and Death |   |   |  |  |
| Box                               | ath certif<br>attending<br>for use as  | Physician/Med     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown  | Fetal death 3                                 | □Ectopic pregnancy<br>□ Other (specify)  |                                      |  | 23d. Date of deliv<br>Month                     | ery<br>Day Year                               |  |  |
| ds, P.O                           | w requires that the debeen signed by the should be detached  | by                | Part II. Other significant conditions contributing to death but no   | t resulting in the u                          | nderlying cause giver  | n in Part I.                         | 23e. Did toba                                      | acco use contribute to t                        | i   |  |  |
| or Vital Records,                 |  | Completed         |  |   |  |                                      | 24a. Was an autopsy perform                        | prior to co                                     | opsy findings available impletion of cause of |  |  |
| Vita                              | sician<br>certifi<br>irector   | Be C              | 25. Was case referred to medical examiner?  1 ☐ Yes - Hospital: 1 ☐ Inpatient  | 2 □ ER/Outpatie                               | Othor  | 26. Place of Death r: 4□ Nursing Hom | - 4  | )<br>nce 6 □Other (Speci                        | (6.1)   |  |  |
| Division or                       | Attending Physician: The death. ector: After this certificate his yethe funeral director, page   | Certification: To | 27. Manner of Death  1 Natural 5 Pending (Month, Day Ye)  2 Accident investigation   | ar) 28b. Time o                               | of 28c. Injury<br>Work?<br>M 1 \(\supers   | at<br>?<br>′es 2 □ No                | 8d. Describe hov                                   | v injury occurred                               |   |  |  |
| Divi                              | oital or Al<br>urs after d<br>sral Direc   |                   | 4 Homicide determined 23e. Place of Injury building, etc. (S   | pecify)                                       |  |                                      | City or Town,                                      |   |   |  |  |
|                                   | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu  | Medical           | 29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examiner on the basis of examiner and manner stated.  |   |  | pinion, death occurre                | ed at the time, da                                 |   | to the cause(s)                               |  |  |
|                                   | Z Z Z S  |                   | In the   |   |  |                                      |  | July 12, 2<br>MD 212                            |   |  |  |
|                                   | (12)   |                   | 30. Name and address of derson who completed cause of death  | (Item 23a) (Type                              | RIDGE  | RD BAI                               | timere,  | MD 212  | 3 7.  |  |  |
|                                   | St<br>Regist   | ate<br>rar        | 31. Date filed (Month, Day, Year)  AUG 1 6 2007  | Signature                                     |  |                                      |  |   |   |  |  |

|  |  |   |  | epartment of Health and N<br>Certificate of Death                                      | lental Hygiene                               | PHHO PERM   |  |  |  |  |  |  |
|--|--|---|--|--|--|---|--|--|--|--|--|--|
|  | Physici  |   | Decedent's Name (First, Middle, Last)     Im Rang Kim  |  | 2. Date of Death<br>Month Da<br>08/15/200    | 3. Time of Death 7 1:49 a   |  |  |  |  |  |  |
|  | /Medic<br>Examin   |   | 4a. Facility Name (If not institution, give street and number)  10121 Bracken Drive  | 4b. City, Town, or Location of Death Ellicott City                                     | 40   | County of Death   |  |  |  |  |  |  |
|  | Funeral<br>Director  |   | 5. Social Security Number 6. Sex 7. Age (In yrs. last birth  |  | 8. Date of Birth (Month, Day, Year)          |   |  |  |  |  |  |  |
| ite, INIGITY INITION A LIZID-0030 stand 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The file and Mental Hygiene and The file and the file | _  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town |  |  | 10d. Inside City Limits<br>1                 |   |  |  |  |  |  |  |
|  | Director   | MD Howard Ellicot   | 10f. Zip Code  |  | tizen of What Country?                       |   |  |  |  |  |  |  |
| ter death w  | items 23a<br>Iner must   | Funeral   | 10121 Bracken Drive  11. Marital Status 1 □ Never Married 2 □ Married 11. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 🖪 No   | 21042  13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto |  | Resident  14. Race - American Indian, Black, White, etc.                    |  |  |  |  |  |  |
| 2 hours at   | atural", or<br>çal Exami   | by  | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:  15. Decedent's Education 16a.  | 1 ☐ Yes 2 ☑ No Specify:  Decedent's Usual Occupation                                   | 16b. F                                       | Specify: Asian  Kind of Business/Industry                                   |  |  |  |  |  |  |
| AIAID Z  | giene.<br>er than "n<br>the Medi   | Completed   | (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or 5+)  Hom   | (Give kind of work done during most of work<br>life. DO NOT use retired)<br>emaker     |  | n Home  |  |  |  |  |  |  |
| 9  | and Mental Hygiene.  is marked other than aumatic event, the Me  | To Be C   | 17. Father's Name (First, Middle, Last) Dae Sup Hong   | 18. Mother's Nam<br>Unknown  | e (First, Middle, Maide<br>Lee               | n Surname)  |  |  |  |  |  |  |
| , Waryia   | ealth and a  |   | Chong Yon Kim / Son 10   | Mailing Address (Street and Number or Rull 121 Bracken Drive, E                        | _  |   |  |  |  |  |  |  |
| Daillimore   | Department of Health a Important: If item 27 is any injury or other tra  |   | 1 Burial 2 □ Cremation 3 □ Removal from State cemeter  | Disposition (Name of y, crematory or other place)  n Memorial Cardens 08/17            |  | cocation - City or Town, State  |  |  |  |  |  |  |
| Dail   | Departr<br>Importa<br>any inj  |   | 21. Signature of Funeral Service-Licensee  | 22. Name and Address of Facility Gary L. Kaufman Fun 7250 Washington Blv               | eral Home a                                  | at MMP, INC.<br>ge, MD 21075  |  |  |  |  |  |  |
| PI   | nysician   |   | 23a part , Fiter the disease, complications aused the death. Do not shoot, or heart failure. List only one author on each line. Immediate Cause (Final disease or condition  | not enter the mode of dying, such as cardiac   | or respiratory arrest,                       | Approximate<br>Interval Between<br>Onset and Death                          |  |  |  |  |  |  |
|  | Medical<br>xaminer   |   | resulting in death)  Due to (or as a consequence of Sequentially list conditions   |  |  |   |  |  |  |  |  |  |
| be executed  | and<br>transit   | Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last  Due to (or as a consequence of consequen |  |  |   |  |  |  |  |  |  |
| S d  | the  | dical E)  | d  |  |  |   |  |  |  |  |  |  |
| O. Box ox  | e attending p  | Physician/Me  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)  |  | 23d. Date of delivery  Month Day Year                                       |  |  |  |  |  |  |
| ords, P.U  | signed by  | by  | Part II. Other significant conditions contributing to death but not resulting in   | the underlying cause given in Part I.  |  | use contribute to the cause of death?                                       |  |  |  |  |  |  |
| Hec<br>L   | ate has been<br>page 2 shou  | Completed   |  |  | 24a. Was an autopsy performed?               | 24b. Were autopsy findings available prior to completion of cause of death? |  |  |  |  |  |  |
|  |  | Be  | 25. Was case referred to medical examiner?  Hospital: Hospital:  | Othor  | th (Check only one)                          |   |  |  |  |  |  |  |
| VISION OF VITA   | within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director, | tion: To  | 27. Manner of Death 28a. Date of Injury 28b. 7   | tpatient 3 □ DOA □ Unit 4 □ Nursing H  Time of   | ome 5 Residence<br>28d. Describe how inj     |   |  |  |  |  |  |  |
| DIVISION   | after deal   | Certification:  | 3 Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, fa building, etc. (Specify)   | rm, street, factory, office  | 28f. Location (Street a<br>City or Town, Sta | and Number or Rural Route Number,<br>te)                                    |  |  |  |  |  |  |
| A Hoenië   | n 24 hours<br>he Funera<br>pletely fille   | edical C  | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.   | d/or investigation, in my opinion, death occu  | rred at the time, date a                     | s) and manner as stated.<br>nd place, and due to the cause(s)               |  |  |  |  |  |  |
| ‡ oF   | Withi<br>To th   | M   | 29b. Signature and title of certifier  | 29c. License number  D2505Y  (Type, Print)  G3   | 29d. D                                       | ate signed (Month, Day, Year)   |  |  |  |  |  |  |
|  | 1  |   | 30. Name and address of person who completed cause of death (Item 23a)   | (Type, Print)  | mo -   | 21067   |  |  |  |  |  |  |
|  | St<br>Regist   | ate<br>rar  | 31. Date filed (Month, Day, Year) 32 Registrar's Signature   | Aparts.  |  | ,   |  |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year lingler 3 2007 /Medical Examiner give street and 4b. City, Town, or Location of Death 4c. County of Death Mary lotte rans Home Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) State or Foreign **Funeral** 3-22-4080 1 M 2□F Months Min Director Tennsi Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Show ns 23a or 28a-f shormust be notified at 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b 062 Completed by Funeral Was Decedent Ever Armed Forces? 1 Yes 2 No 1 Yes Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry
) nited States Elementary/Secondary (0-12) College (1-4or 5+) la echanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), 20040 19a. Informant's Name/Relationship (Type. Prilit) MOOD 150 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest 07 21. Signature of Funeral, Service Licenses Del+Crewa EvanstuneralCha ta 23a. Pall1. Enter the dise shock, or heart failur plications that c.u. ed the death. Do not enter the mode of dying, such as lardiac or respiratory arrest one cause on elich line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed After this certificate has been signed by the aftending physician and funerel director, page 2 should be detached for use as the burial-tran Due to (or as a cor Division or Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 I Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 ☐ Accident Injury 1 ☐ Yes 2 No after death. death. 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) DC657574 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29449 Charlotte Hall, mo Heshmat Charlotte Dr. Ahmed 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

Registrar
DHMH 17 Rev 1/2001

AUG 1

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year GEARGIAN ANN 3:07 PM 2007 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL HOW BORN COLUMBIA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F 149-16-4136 82 Director Sept.1,1924 New Jersey Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or a important: if item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be none. 3020 North Ridge Road, W303 21043 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes X☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Oil Filters 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George A. Kress Teresa Gordon ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 35 Monksville Court, Ringwood, NJ 07456 George Kress, Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rosehill Crematory 08/18/2007 Linden, New Jersey 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility The Gundrum Service Must M01113 237 Bordentown Ave., South Amboy, NJ 08879 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** INTRACT ABL METABOLIC HOURS resulting in death) /Medical Due to (or as a consequence of): Examiner PANCREATIT HUNRS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 - No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No iours after death.

neral Director: A
filled in by the fu 2 Accident investigation 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C 1 Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1)42892 when no AUG 16 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21044  $\mathcal{Q}_{j}$ 

State Registrar

Atts 1 7 2007

31. Date filed (Month, Day, Year)

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Aggistrar's Signature

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|---------------------|--|----------------|---|---|-------------------------|------------------------|--|--------------------------------|--|----------------------------|---------------------------|---------------------------|-------------------------------|----------------------|
|                     |  | •              | 1 - For<br>State<br>Registrar   | Oldie of Mi   | arylaria /              |                        | tificate of                                |                                | ia McMai ii                                    | Reg. N                     | 75.25                     | 4.7                       | 06                            | 0                    |
| 1                   |  |                | Decedent's Name (First, Middle, L.  | _ast)   |                         |                        |  |                                | 2. Date of I                                   | eath                       |                           |                           | 3. Time of                    | Death                |
| н                   | Physici<br>/Medic  |                | Diana   | $\sim$  |                         | H                      | Raniecki                                   |                                | Augus  |                            |                           | Year<br>.00 <b>7</b>      | 4:30                          | <b>→</b> M           |
|                     | Examin   |                | 4a. Facility Name (If not institution, g  | ive street and number)  | C                       | enter                  | 4b. City, Town, o                          | Location of I                  | Death  | 4                          | c. County o               | of Death                  |                               |                      |
| €.                  |  |                | Johns Hopkins ?   |   | edical                  |                        | Baltor                                     |                                |  |                            |                           | N/A                       |                               |                      |
| n                   | Funeral  |                | 5. Social Security Number 6. 216–58–4975  | Sex 7. Ag   | e (In yrs. last b<br>56 | oirthday)<br>Yrs.      | if Under 1 Year<br>Months Days             |                                | Min. 8. Date of E<br>(Month, I<br>OCT 3        | Birth<br>Day, Year<br>O 10 | 50                        | 9. Birthpl<br>Count<br>NC | ace (State o<br>try)          | r Foreign            |
|                     | Director   |                | Usual Residence of Decedent   |   | 70                      |                        |  |                                | 001 3  | 0 19                       | 00                        | INC                       |                               |                      |
|                     | yland<br>how<br>at   |                | 10a. State 10b. County 10c. City, Town or Location  |   |                         |                        |  |                                |  |                            |                           | 10                        | d. Inside Cit                 |                      |
|                     | e Ma<br>Ba-f s   | Director       | MD N/   | A   | Balt                    | imor                   | 1  |                                |  |                            |                           |                           | 1 X Yes                       | 2 [] No              |
|                     | with the   |                | 10e. Street and Number  |   |                         |                        | 10f. Zip Code                              |                                |  |                            |                           |                           | try?                          |                      |
|                     | is 23  | eral           | 6402 Eastern Av   | 21224   | isnanic Origin          | n? (Snecify Yes or I   | Vo-  | USA<br>14. Race                | - America                                      | an indian.                 |                           |                           |                               |                      |
|                     | r iten   | Funeral        | 1 Never Married 2 Married   | 12. Was Decedent<br>Armed Forces?<br>1 ☐ Yes 2 🔀                    |                         |                        |  |                                | n? (Specify Yes or I<br>Puerto Rican, etc.)    |                            |                           | , White, e                |                               |                      |
| Maryland 21215-0036 | be filed within 72 hours after death with the Maryland<br>Ital Hygiene.<br>d other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notified at | þ              | 3 ☐ Widowed 4 🏿 Divorced  | If Yes, Give<br>Year or Dates:                                      |                         |                        | 1□Yes 2≦ No                                | Specify:                       |  |                            | Specify:                  | Whi                       | te                            |                      |
| 2                   | 72 hc<br>'natur<br>dical   | etec           | 15. Decedent's (Specify only highest of   | Education grade completed)  | 16                      | a. Deced<br>(Give      | dent's Usual Occup<br>kind of work done    | ation<br>during most o         | of working                                     | N                          | Kind of Bus               |                           | ustry                         |                      |
| 121                 | within<br>ene.<br>than '   | Completed      | (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  (Give kind of work done during most of working life. DO NOT use retired)  Shipper/Receiver   |   |                         |                        |  |                                |  |                            | Chemical<br>Industry      |                           |                               |                      |
| <b>d</b> 2          | filed<br>Hygir<br>Sther<br>ent, th   |                | 17. Father's Name (First, Middle, La  | st)   |                         | PF                     | CL/ RECEL                                  |                                | s Name (First, Midd                            |                            |                           |                           |                               |                      |
| an                  |  | To Be          | Lee Roy J. Clar   | k   |                         |                        |  | B1a                            | nche_M. B                                      | urre                       | 11                        |                           |                               |                      |
| ar                  | 2 shou<br>and N<br>is mai  | -              | 19a. Informant's Name/Relationship  | (Type. Print)   | I                       |                        | _  | and Number                     | or Rural Route Nun                             | nber, City                 | or Town, S                |                           | ,                             |                      |
|                     | # 22 ± 1   |                | Frank Kaniecki  | - son   |                         |                        |  |                                | Dundalk,                                       |                            |                           |                           |                               |                      |
| Baltimore,          | 0 0  |                | 20a. Method of Disposition<br>1 ☐ Burial 2   Cremation 3  | ☐Removal from State   |                         |                        | sition (Name of<br>matory or other plac    |                                | Date   | 20c. l                     | _ocation - (              | City or To                | wn, State                     |                      |
| Ħ                   | permit. Pag<br>Department<br>Important: I<br>any injury o  |                | 4 □ Donation 5 □ Other (Special Light State of Euparal Service Light  | **  | Metro                   |                        | ematory,<br>2. Name and Addre              |                                | 3/16/2007                                      | _Ba                        | ltimo                     | ore,                      | MD                            |                      |
| Ba                  | permit. Pag<br>Department<br>Important: I<br>any injury o  | Ų Į            | 21. Signature of Funeral Service Lic  | dd Dring  |                         | 1                      | Cremation                                  | n Soci                         | ety of Ma<br>Road, Bal                         | ryla                       | nd, I                     | nc.                       | 200                           |                      |
|                     |  |                | 23a. Part1. Enter the disease, or co  | emplications that caused  | the death. Do           | o not ent              | er the mode of dyir                        | ig, such as ca                 | ardiac or respiratory                          | arrest,                    | re, M                     | D 21.                     | Approximate<br>Interval Bet   | e                    |
|                     | Physician  | G I            | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition |   |                         |                        |  |                                |  |                            |                           |                           | Onset and I                   | Death                |
|                     | /Medical   |                | resulting in death)   |   | a consequenc            |                        |  |                                |  |                            |                           |                           | - (                           | <del></del>          |
|                     | Examiner   | Ļ              | Sequentially list conditions,   | b. Bowe   | a consequenc            | che.                   | mia  |                                |  |                            |                           | _                         | 3 day                         | <u>5</u>             |
|                     | ted<br>nsit  | nine           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as   | a consequenc            | e oi).                 |  |                                |  |                            |                           |                           |                               |                      |
| <b>~</b>            | te be executed<br>ysician and<br>te burial-transit   | Examiner       | that initiated events c. Due to (or as a consequence of):   |   |                         |                        |  |                                |  |                            |                           |                           |                               |                      |
| 3760,               |  | ical           |   |   |                         |                        |  |                                |  |                            |                           |                           |                               |                      |
| 99                  | The law requires that the death certificate ate has been signed by the attending phy bagge 2 should be detached for use as the   | Physician/Med  | IF FEMALE:  |   |                         |                        |  |                                |  |                            |                           | -                         |                               |                      |
| Box                 | ath ce   | ian/           | 23b. Was decedent pregnant in the past 12 months?   |   |                         |                        |  |                                |  |                            | 23d. Date<br>Mor          | of delive<br>oth          | *                             | Year                 |
| o.                  | the de   | ysic           | 1 □ Yes 2 □ No<br>9 ☑ Unknown   | 4□Pregnant a<br>9□Unknown   | t time of death         | 5L                     | Other (specify) _                          |                                |  | -                          |                           |                           |                               |                      |
| <u>.</u>            | N requires that the dispension of the signed by the should be detached   | by Ph          | Part ii. Other significant conditions   | s contributing to death b   | ut not resulting        | in the u               | nderlying cause giv                        | en in Part i.                  | 23e. Di  | d tobacco                  | use contr                 | ibute to th               | e cause of d                  | leath?               |
| Records,            | equires<br>en sig<br>ould be   | ed b           | 1 □ Yes 2 □ No  |   |                         |                        |  |                                |  |                            |                           | 3 🗌 Prob                  | ably 4 🗹                      | Jnknown              |
| ပ္ပ                 | law re<br>as ber<br>2 sho  | Completed      |   |   |                         |                        |  | ·                              | 24a. Wa  | topsv                      | 24b. V                    | Vere auto                 | osy findings<br>npletion of c | available<br>ause of |
|                     |  | Соп            |   |   |                         |                        |  |                                | pe<br>1□ Yes                                   | rformed2                   | lo 1                      | eath?                     |                               |                      |
| Vital               | Physician: The law<br>this certificate has t<br>al director, page 2 s  | Be             | 25. Was case referred to medical examiner?  | Hospital:   |                         |                        | a acido Oth                                | or:                            | of Death (Check onl                            |                            |                           |                           |                               |                      |
| Ö                   | Phys<br>r this<br>ral di   | : To           | 1 Yes 2 No 27. Manger of Death  | 28a. Date of Inju   | ury 28b                 | o. Time o              | " JUDON                                    | 4 🗀 Nurs                       | sing Home 5 Re<br>28d. Describ                 |                            |                           |                           | /)                            |                      |
| on                  | Attending Physician: r death. ector: After this certificative funeral director;  | ation          | 1 Natural 5 Pending<br>2 Accident investigat  | (Month, Da  | y Year)                 | Injury                 |  | ƙ?<br>Yes 2∐No                 |  |                            |                           |                           |                               |                      |
| Division or         |  | Certification: | 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |                         |                        |  |                                |  |                            |                           |                           | iber,                         |                      |
|                     |  |                |   |   |                         |                        |  |                                |  |                            |                           |                           |                               |                      |
|                     | To the Hospital or within 24 hours affer To the Funeral Dir completely filled in   | Medical        | 29a. Certifier 1 Certifying (Check only one) 2 Medical Ex   | Physician: To the best<br>caminer: On the basis of<br>and manner st | of examination          | lge, deat<br>and/or in | h occurred at the ti<br>vestigation, in my | me, date and<br>opinion, death | place, and due to to<br>n occurred at the time | ne cause<br>ne, date a     | (s) and ma<br>nd place, a | nner as st<br>and due to  | ated.<br>the cause(s          | s)                   |
|                     | ro the vithin ro the ro the romple   | Mec            | 29b. Signature and title of certifier   | and manner st   |                         |                        | 29c. Licens                                | e number                       |  | 29d. D                     | ate signed                | (Month,                   | Day, Year)                    |                      |
| )                   | ->-0   |                | 1 Cish link   | Hich  |                         |                        | 294  | -000                           |  | Au                         | qust                      | 15                        | 2007                          |                      |
|                     | Ī  |                | 30. Name and address of person wh   |   |                         |                        | Print)                                     |                                |  | •                          | ,                         |                           |                               |                      |
|                     |  |                | _ / /   | 1 -11-0 10  | 40 500                  | 10 -                   | V-10 0.10                                  | L                              | male n   | Man.                       |                           | ·                         | 1                             |                      |

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year /Medical Janet Forstein 15 Kane August 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Riverview Nursing Home Essex Batlimore Co. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 ₩ F Director Yrs. 217-34-5412 70 Feb. 13,1937 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Directo 1 ☐ Yes 2 ☐ No Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7838 Lockwood Road Funeral 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify ò Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Homemaker other Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert E. Good ည Ruby M. Haugen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James Kane (Husband) 7838 Lockwood Road Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 8/20/2007 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, XXXX 7922 Wise Ave. Dundalk, Maryland e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a, Part1./E Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** eproval (wa /Medical Due to (or as a consequence of) Examiner rden Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a obsequence of): physician and s the burial-trans Division or Vital Records, P.O. Box 68760 T Physician/Medical as attending p IF FEMALE: use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 5 Other (specify) ed by the a detached f 9☐ Unknown 9 Unknown ו signed by ti 1 be חבר Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate har funeral director, page 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ExertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29c. License number

Schenne

1) 002213-1

29d. Date signed (Month, Day, Year)

and manner stated.

3023 Eastern

32 Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

title of certifier

Sebastian John

31. Date filed (Month, Day, Year)

29b. Signature and

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend 16b, perFH, G870, 8/17/07 TT Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 200 CONTORO VICH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** JUSPIT Northwest Centel 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 5-45-1416 Months Days 1 M 2 □ F **BELARUS** 30 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ural", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6807 PARK HEIGHTS AVENUE # 1-J 21215 American Indian, Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Agriculture r than Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed within the Health and Mental Hygiene. **SPECIALIST** 5+ **AGRIULTURE** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) B MORDECHAI KANTOROVICH LEAH MEYTIN ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) GALINA KATSNELSON / DAUGHTER 3304 TERRAPIN ROAD - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARLINGTON CHIZUK
AMUNO CONG
22. Name and Address of Fecility permit. Pages 1 a
Department of HeImportant: If item
any Injury or othe Date 20c. Location - City or Town, State 20a. Method of Disposition 1 🛣 Buriai 2 □ Cremation 3 □ Removal from State 08/16/2007 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. MD 21208 8900 REISTERSTOWN ROAD - PIKESVILLE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MRhane ofto Physician 127 tron /Medical or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and Due to (or as a consequence of) burial-t Division or Vital Records, P.O. Box 68760, by the attending physician tached for use as the burial Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy Year Month Day 5 Other (specify) be detached ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Doknown 1 ☐ Yes 2 ☐ No 3 Probably page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has 1☐ Yes 20 Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 2[**X**No 1 Inpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 2 ER/Outpatient 2 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: (Month, Day Year) Injury 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No M 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Flural Floute Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) me and address of person wh completed cause of death (Item 23a) (Type, Print) ROA 019 401 Cre 32 Registrar's Signature Date filed (Month, Day, Year) State AUG 1 7 2007 Registrar

| 07-062 | 40  |        |  |
|--------|-----|--------|--|
| Maurv  | Ira | Kandel |  |

| iury Ira Kande   |                | 1- For State   | State of                 | Maryland /                      |              | tment d<br><i>ificate d</i> |                    |               | Mental I                    |                    | Pog. No.               | ) )           | 7 201  | 9        |
|--|----------------|--|--------------------------|---------------------------------|--------------|-----------------------------|--------------------|---------------|-----------------------------|--------------------|------------------------|---------------|--|----------|
| Physici  | an/            | Registrar<br>1. Decedent's Name (Firs                  | t, Middle,Last)          |                                 |              |                             |                    |               |                             | 2. Date of De      | Reg. No.<br>ath<br>Day | Year          | 3. Time of Death   | $\neg$   |
| edical Exami   | iner           | MAURY  4a. Facility Name (if not in                    |                          | I                               |              |                             | KAND               |               | )                           | August 1           | 3, 2007                |               | 1220 hrs   | _        |
| 1  |                | 3105 Bancroft R  |                          |                                 |              |                             | Baltir             |               | ocation of Dea              | aun<br>            | 40. 000                | inty of Death |  |          |
| Funeral  | ,              | 5. Social Security Number                              | r 6. Sex                 | 7. Age                          | (in yrs. las | t birthday)                 | If Und             | er 1 Year     | If Under 24H                | Irs. 8. Date of E  | irth (MM/DD/Y          | Foreig        |  |          |
| Director   |                | 215-48-9271  |                          | 2 F                             | 56           | Y                           | rs.                | - Days        | Tiodis                      | 02/26              | 1951                   | Co            | untry) MD  | _        |
| any and any any  | .1 -           | Usual Residence of Dece<br>10a. State 10b. 0           | County                   | 1                               | 0c. City, T  | own or Loc                  | ation              |               |                             | <u>:</u> _         |                        |               | .10d. Inside City Limit  |          |
| and<br>f show  | or             | MD   | N/A                      |                                 | В            | ALTIM                       | ORE                |               | ÷                           |                    |                        |               | 1 X Yes 2 N  | lo       |
| Mary<br>r 28a-   | Director       | 10e. Street and Number                                 | ICDAET D                 | OAD ADADT                       | MENT         | D                           | 10f. Zi;           | Code 215      |                             | 100                | 10g. Citizen o         | of What Coul  | ntry?  |          |
| r death with the Maryland<br>or items 23a or 28a-f show<br>must be notified at once,   |                | 11. Marital Status                                     |                          | OAD APART                       |              |                             |                    |               | anic Origin? (              | Specify Yes or N   |                        |               | can Indian, Black,   | $\dashv$ |
| death v  | Funeral        |  | Married 1                | Armed Forces? Yes 2             | No           |                             |                    |               |                             | rto Rican, etc.)   | 1                      | White, etc.   |  |          |
| safter<br>rral", o   | ò              | 3 Widowed 4  15. Decedent's Education                  | X Divorced If Y          | Dates:                          | leted)       |                             | Yes 2              |               | specify:<br>in (Give kind o | of work done       | Spec                   | of Business/  | HITE   | -        |
| 72 hour<br>n "nate   | eted           | Elementary/Secondary                                   |                          | College (1-4 or 5+              |              | during                      | most of wo         | rking life. I | OO NOT use r                | etired)            | ·                      | or Edsiriess/ | The state of the s | -        |
| 0036<br>within<br>iene.<br>er thau   | Completed      |  |                          | 2                               |              | C0                          | MPUTE              |               | HNICIA                      |                    |                        | MPUTER        | TER  |          |
| b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Montal Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once | Be C           | 17. Father's Name (First, HERMAN                       | Middle, Last)            |                                 | KΔN          | DEL                         |                    | 18            | 3.Mother's Na<br>DOROTH     | me (First, Middle  | , Maiden Sum           |               | RANK   |          |
| 212<br>1016 b<br>10 Mein<br>is mart<br>tic eve   | ToE            | 19a. Informant's Name/R                                | elationship (Type        | , Print )                       | 10/11        | 19b. Mail                   | -                  | ,             | and Number of               | or Rural Route N   |                        | Town, State   | e, Zip Code)   |          |
| MC shind 2 steem 27 rauma  | Ξ.             | SHARON FRIE  |                          | TER                             | 20h Pi       | 100                         |                    |               |                             | 201 - RO           |                        |               | 20850<br>Town, State   | _        |
| Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important; If ritem 27 is marked other it nijury or other traumatic event, the Med         |                | 1 X Burial 2 Cr  | remation 3               | Removal from State              |              | ematory or<br>ISAA          | other place        |               |                             | 3/16/200           | i i                    |               |  |          |
| Baltin<br>permit; Pa<br>Departmen<br>Importan  | 1              | 4 Donation 5 C   |                          | $\wedge$                        |              |                             | RAFI<br>. Name and | Address of    | of Facility                 | SOL I              | FVINSO                 | N & RF        | ROS., INC.   | 12       |
|  |                | 23a. Part I. Enter the Ise                             | ) w                      | HI                              |              |                             | 890                | O RE          | STERSI                      |                    |                        |               |  | 20       |
| Physician<br>/Medical  |                | failure. List only one                                 | e cause on each l        | line.                           | ne death. I  | Do not ente                 | r the mode         | of dying, s   | uch as cardia               | c or respiratory a | rrest, shock, o        | or neart      | Between Onset an   | id       |
| aminer   |                | Immediate Cause (Final or condition resulting in c     |                          | nging<br>to (or as a conseq     | uence of)    | :                           |                    |               |                             |                    |                        |               |  |          |
|  | jr,            | Sequentially list condition if any, leading to immedia |                          | e to (or as a conseq            | uence of)    | <u> </u>                    |                    |               |                             |                    |                        |               |  |          |
| 0  | Examiner       | cause. Enter Underlying<br>(Disease or injury that in  | Cause c.                 |                                 |              |                             |                    |               | ,                           | 01 555             |                        | (28)          |  |          |
| ansit and RA   | Exa            | events resulting in death                              |                          | e to (or as a conseq            | juence of)   | :                           |                    |               |                             |                    |                        |               |  |          |
| 50, c. te be executed sysician and burial - transit  | ledical        | UNPENDED AMENDED                                       |                          |                                 |              |                             |                    |               |                             |                    |                        |               |  |          |
| Box 68760, e death certificate buthe attending physicate but of for use as the but   |                |  |                          |                                 |              |                             |                    |               |                             |                    |                        |               |  |          |
| Box 6876<br>death certifical<br>he attending ph<br>d for use as the  | Physician/N    | past 12 months?  | Unknown                  | 4 Pregnant at ti                | me of dea    | AL                          | Other (Spe         |               |                             |                    |                        |               | ,  |          |
| he i   | Phys           | Part II. Other significant                             | Contract Contract        | 9 Unknown  ntributing to death  | but not re   | sulting in the              | e underlyin        | g cause giv   | ven in Part I.              | 23e. Did           | tobacco use            | contribute to | the cause of death?  |          |
| , P.O. res that the signed by be detacled  | d by           |  |                          |                                 |              | _                           |                    |               |                             | _ 1 _ Y            | es 2 🗸 No              | 3 Pro         | bably 4 Unknown  | n        |
| of Vital Records, ng Physician: The law requir Nher this certificate has been s meral director, page 2 should I  | ompleted       |  |                          |                                 |              |                             |                    |               |                             |                    | opsy                   | prior to      | utopsy findings availat<br>completion of cause o   |          |
| Recc<br>The lar<br>cate ha   | l mox          |  |                          |                                 |              |                             |                    |               |                             |                    | formed?<br>2 ✓ No      | death?        | es 2 No  |          |
| ital Fician:<br>s certifications   | Be C           | 25. Was case referred to examiner?                     |                          | pital: 1 Inpatien               |              | ER/Outpatie                 | - 2 T              |               | of Death (Che<br>Other Nu   | ck only one)       | Docidence              | 6 ✔ Othe      | r: Caaaa   |          |
| n of V<br>ding Phys<br>1.<br>After this<br>funeral di  | 1.7            | 1 ✓ Yes 2<br>27. Manner of Death                       | No                       | 28a. Date of Injury             |              | 28b. Time o                 |                    | 28c. Injury   |                             | 28d. Describ       | e how injury o         | ccurred       | . Scene  |          |
|  | ation          | 1 Natural 5 2 Accident                                 | Pending<br>Investigation | FOUND: Day, Yes                 |              | FOUND:<br>1213 hrs          |                    | 1 Y           | es 2 🗸 No                   | Subject ha         | inged self             |               |  |          |
| Division tal or Attendin rs after death. al Director: A ted in by the fu   | Certification: | 3 Suicide 6  | Could not be determined  | 28e. Place of Inju              | •            |                             |                    | y, office bu  | ilding, etc.                | or Town            | State)                 |               | ural Route Number, Ci  | ity      |
| Divis the Hospital or At hin 24 hours after d the Funeral Direc mpletely filled in by  |                | 4 Homicide 29a. Certifier 1 Certi                      |                          | (Specify) Tow To the best of my |              |                             |                    | e time, dat   | e and place, a              |                    |                        |               | Baltimore, MD  |          |
| Division  To the Hospital or Attend within 24 hours after death To the Funcral Director; completely filled in by the   | Medical        |  | cal Examiner: Or         | the basis of exam               |              |                             |                    |               |                             |                    |                        |               |  |          |
| FSFS   | ž              | 29b. Signature and title of                            |                          | <i>a</i> • • •                  |              |                             | 29                 | c. License    |                             |                    | 1                      | - '           | onth, Day, Year)   |          |
|  |                | 20 Name and side                                       | OL H                     | tella                           | ath /ltom    | 23a)                        |                    | O.C.N         | 1.⊏.                        |                    | August                 | 14, 2007      |  | _        |
| 12   |                | 30. Name and address of Carol Allan, MD                |                          | Medical Exam                    |              |                             | Street,            | Baltimo       | re, MD 21                   | 201                |                        |               |  |          |
|  | tate           |  | d and t                  | Registrar's                     | Signatur     | e                           | 1.0                |               |                             |                    |                        |               |  |          |
| Regis  | uel            | AUG 3  | 7 2007                   | 15 18 115 1                     | 130          | LA STA                      |                    |               |                             |                    |                        |               |  |          |

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Daniel G. Leach 2007 6:20 AM August 14, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Yrs. 53 Director September 24,1953 515-48-8972 Kansas Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 Tyes 2 No Director Florida Port Charlotte Charlotte 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20437 Spangler Terrace 33954 permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28s any Injury or other traumatic event. the Medical Examiner must United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>\$</u> 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 18b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician Electrial Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Robert F. Leach Lucille Hackerott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 900 Boyds School Road Gettysburg, Pennsylvania 17325 Charles W. Leach/ Brother 20b. Place of Disposition (Name of cemetery, crematory or other place)

Montgomery
Crematorium inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 17, 2007 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Eorium Inc. 17, 2007 | Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850–2805 21. Signature of Funeral Service Licensee Rockville, Rockville, M00335 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Minutes disease or condition resulting in death) ortic /Medical Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed sician and burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, aftending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signage 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 No 2□ No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: To the Hospital or Attending Physical addition 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. ပ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Doo 6332 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 G. BAKHTIARI MD POOPAK 9901 MEDICAL CENTER DRIVE ROCKVILLE MD 20850

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

**ORIGINAL** 

32. Registrar's Signature